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Digging down and scaling up: A psychosocial exploration of the Family Nurse Partnership

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University of Sussex**

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University of Sussex and
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Declaration

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree

Signature.....

Summary

This PhD has been produced through a collaboration between the University of Sussex and the Family Nurse Partnership (FNP). FNP is a public health, preventative, home visiting programme for first-time young parents, delivered by specialist family nurses. It was developed in the 1970s by Professor David Olds in the USA. Several Randomised Control Trials lent the programme international credibility, such that the FNP was introduced into the UK in 2007, overseen by a National Unit hosted by Public Health England. There are now approximately 80 sites across England, commissioned by Local Authorities and delivered by local health (usually NHS) providers.

In contrast to the extant evaluative RCT research on FNP, this explorative study follows a qualitative methodology to 'dig down' into phenomenological local practices. The purpose is to provide a conceptualisation of the model which assists the National Unit in their efforts to adapt to the contemporary UK context. Located within a social work department, with a focus on a nursing/health organisation, the study's interdisciplinary underpinnings have facilitated the asking of broad, existential primary questions about how the FNP model operates, is understood and experienced in practice and about the opportunities and obstacles to operationalising the FNP model which exist for its operationalisation across the micro, meso and macro system levels. From a methodological point of view, the study also asks how psycho-social methods can address such questions. Sub-questions provide a focus for the study on the interplay between the social environment of teenage parents and the FNP model; the role of austerity; FNP's primary task; the psycho-social development of teenage parents and its links with the FNP model; and the relationship between social policy, the FNP approach and the teenage parents in the study.

Having gained NHS ethical permission via the Health Research Authority, the study deployed psycho-socially oriented research methods to collect data from within a single FNP site. This involved an eight month ethnographic observation of home visiting and office based activity and one-to-one interviews with professional and client

participants. To provide triangulation and comparison, further interviews and focus groups were conducted within three additional FNP sites in different areas, which involved FNP clients, family nurses and wider stakeholders.

The analytical process continued the psycho-social focus and utilised an adapted version of the Listening Guide method to produce a multi-focal perspective on the operationalisation of the FNP model. Drawing on critical social policy, sociological, systems, cultural and psychoanalytic theories, the argument develops a contextualised understanding of this highly complex arena, in which there are multiple interests and influences at play. A rare example of organisational and practice orientated research which includes the perspectives of both those who 'deliver' (at various organisational levels) and those who 'receive' services, the analysis reveals layers of paradox, ethical tension and complex power dynamics within the 'primary task/s'. It considers how teenage parents, and mothers in particular, are positioned within policy and popular discourses as disempowered, and the implications of this for the FNP model.

The discussion develops an appreciation of the multi-layered contexts of FNP's work by considering the often unconscious interplay between affective and social contexts, revealing the way that individual and organisational processes intersect one another. The study implications point towards opportunities for the FNP model to expand its systemic roots beyond current manifestations. Bringing the experiences of family nurses and teenage parents to the fore, it asks whether a more collectivist, and less individualistic approach might be a sustainable and ethical route towards realising FNP's aim of affecting global change and considers diverse ways of valuing and measuring the relational aspects of the work. Providing helpful methodological learning about the nature of empirical psycho-social research into organisations – of which there are few – the study highlights the merits of this approach, which provides rich data, reflective of the complexity of human life and human service organisations. Aligning itself with current critical social policy and qualitative research with teenage parents, the study uses this data to advocate for a more diverse and less deterministic conceptualisation of teenage parents within the policy and practice arena.

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Glossary of terms

Transference

The transmission of unconscious feelings. Conceived within the Object Relations tradition (Klein, 1952) to describe the process by which an analyst experiences the feelings of their analysand as if it were their own. Careful reflection is required to tease out where feelings and behaviours might 'come from'. Following Group Relations thinking, the concept has been latterly applied to consider how affect is 'passed around' within social systems, including research settings (Hollway and Jefferson, 2000).

Containment

This is Bion's (1962) theory describing how mothers process the feelings of their babies, through the process of 'reverie', enabling them to tolerate their anxieties. Applied more broadly we can see that when uncontained anxieties become unbearable - in individuals, groups or entire populations - they are 'projected' or thought to belong to others, who either keep them or 'project' them onto those they consider more disadvantaged than themselves (Woodward, 2015).

Defences against anxiety within social systems

This is a continuation of the Freudian idea (1894) that we protect ourselves against remembering anxiety provoking experiences, memories or feelings using psychic defences. Applied to social settings, Menzies-Lyth (1959) and others have demonstrated how organisations can develop defensive behaviours which are counter to their intended task, as a way of managing uncontained work related anxiety.

The depressive position

Following Klein (1935) again, this describes an infant's psychic development, from 'paranoid schizoid' – where the world is experienced as either all 'good' or all 'bad'; to 'depressive position' thinking – where there is an integrated understanding that 'good' and 'bad' can co-exist within one person, namely the mother. Applied to social contexts, these processes are useful for thinking about our tendency to split others using simplistic binaries, particularly when we feel under threat. It is recognised, therefore, that reaching a balanced, 'depressive position' requires containment.

Chapter 1: Introduction

Study background

This thesis presents my PhD in Social Work and Social Care, which centres on the Family Nurse Partnership (FNP) model. It explores the practice implementation of the FNP model through the experiences of participating clients, practitioners and the operational managers who oversee it, by unpacking the meanings and emotional significance it holds for them. FNP is a preventative community based public health initiative, which utilises methods from multiple disciplines to promote the wellbeing of young parents and their children. Arriving in the UK from the USA in 2007, it deploys family nurses to deliver a structured programme aimed at improving outcomes across several health, educational and social indicators. Family nurses are trained in person-centred and strengths-based methods to engage young parents, with the goal of establishing mutually respectful relationships. These are developed during regular home visits, beginning in pregnancy and ending with the child's second birthday. Relationships are also an important part of the managerial structure of the FNP model, with family nurses receiving weekly one-to-one and monthly group supervision, which aims to be reflective and emotionally containing.

The FNP has a National Unit (NU) which oversees clinical, training and strategic development on behalf of its network of approximately 80 local sites across England. In 2014, its senior leadership approached Professor Gillian Ruch regarding a doctoral collaboration between the University of Sussex and FNP. Aware of Professor Ruch's work in organisational containment and relationship-based practice, the NU was interested in commissioning research to complement existing knowledge about the efficacy of the programme with explanatory learning. Rather than evaluating, this study aimed to explore and understand processes at play within the FNP model. Taking a qualitative approach, would, it was hoped, contextualise existing quantitative research, quality assurance data and practice knowledge. A substantially different type of empirical study about FNP activity than had previously been undertaken was required to provide the NU with the opportunity to take a deeper look at the

phenomenological experiences and related meanings that clients, nurses and wider stakeholders attach to its model. The richness of understanding emerging from such a study would be utilised by the NU to inform future adaptations of the model for the UK context.

The doctoral scholarship advertisement developed from the early collaborative conversations described the NU's interest in focusing on the relational aspects of its practice and the opportunity to deploy a psycho-social frame to take a broad and reflective look at the model. I applied to join this collaboration due to my interest in the psycho-social dimensions of organisational practice and relationship-based approaches to practice - both of which began during my Social Work MA training at the Tavistock and Portman NHS Trust. As part of this course of study, I had researched reflective supervision and published an essay on the authority structures within contemporary team roles. Along with the opportunity to further these interests, studying FNP was also attractive to me because of my experience of working with preventative and participatory approaches within both early years and adolescent settings.

It is important to say from the outset that this is, therefore, a commissioned piece of academic research, partly financed and supported by the organisation under scrutiny. Early on in the PhD programme, my supervisor and I met with the NU Director and a Clinical Lead, to form the collaboration partnership, which met quarterly throughout the study. These became forums for reflection and negotiation, particularly during the first year the balance of influence within the study direction. As a novice researcher with twenty years of professional experience, my initial approach was to treat the PhD project as a work task, namely, to work with the brief, executing it to the best of my abilities. As the methodology chapter explains in more detail, during the first year, my position shifted, as I understood my role to be that of an independent researcher within an academic training programme, needing to balance FNP's interests with my own. The openness of the NU leadership allowed for this shift to take place without friction, enabling me to more deliberately 'take the wheel' in order to steer the research study in a way that gave me greater intellectual freedom.

However, throughout the study, I continually grappled with how to write critically in a way that did not criticise or expose either individuals or FNP as an organisation. Particularly when it came to sensitive data, questions about what to share, how, with whom and why were continually in mind. From the outset, my aim for this study was to marry form and content – i.e. to study a relational programme using relational research methods, and the collaboration partnership was no exception in this regard. We developed strong relationships of trust and respect, which enabled honest and thoughtful discussion about the dilemmas I encountered. We also shared a commitment to genuinely learning something new about FNP, in a way that was as respectful and as strengths-based as possible.

Despite this, my position meant that I faced a complex set of ‘accountabilities’ – a theme I develop during the thesis in relation to family nurses and supervisors. I felt accountable to two funders, an academic institution, participants (including local site professionals, clients and National Unit leaders) and to myself - my relationally orientated values and ethics. I also felt accountable for honouring the data and ‘telling the truth’, and sometimes it was not obvious to me how I might reconcile these ‘accountabilities’. Far from being a weakness in the study, however, these deliberations and tensions were, I believe, a strength. The fact that I grappled with these issues personally, and that we explored them in-depth within the collaboration partnership, led, I believe, to a high level of intellectual and relational integrity within the work – as expanded within the methodology chapter. However, whilst the study that follows, does not shy away from problematic and sensitive data, it remains the case that it is not, and does not seek to be, an independent, external evaluation, but rather a collaborative, honest and reflective account of FNP’s model, from a complex insider-outsider position.

From very early on, the study title drew on the metaphor of ‘digging down’ and ‘scaling up’. These images became very generative for exploring ideas during the research, and their significance and meanings changed over time. Originally, they reflected the NU’s interest in learning about the replication of core model features (such as relationality) beyond the micro level. Later however they became useful for describing the

methodological approach of looking in-depth at a small number of ‘cases’ to learn about what could be happening at scale across the whole system. Later still, the metaphor reflected the way that I used phenomenological experiences gathered during fieldwork (digging down) to develop conceptual knowledge of the FNP model (scaling up). Throughout the process I stayed true to this dual focus - of looking at the detail in the light of the larger emerging ‘map’ - a “zooming in and zooming out”, to borrow from the title of Nicolini’s paper on practice based research (2009). This involved nurturing a close mental relationship between, for example, individual psychological processes and political social policy. Doing this allowed me to trace and theorise aspects of the system which, although they may have been known at the level of feelings before, may not have been articulated in such a way that they could inform organisational development. The study presented here therefore, describes how the FNP model, as a contemporary social intervention, within the contested social policy area of teenage parenting, contains inevitable paradoxical and ethically complex elements. As a close study of phenomenological operationalisation, it supports both conceptual and implementational advances by providing a rich appreciation of the contextual features surrounding FNP activity, its obstacles and opportunities.

One of the outcomes of the re-positioning described above was the creating of research questions that would allow for digging and scaling to take place through open, explorative inquiry. The questions were formulated, therefore, as follows:

- 1) *What is the FNP model and how is it understood, operationalised and experienced in practice?*
- 2) *What are the opportunities and obstacles to operationalising the FNP model across the micro, meso and macro domains?*
- 3) *How can psycho-social research methods help to answer these questions?*

Just as the scaling and digging in the study title evolved, it is also the case that the study questions continued to develop during the study. As the analytic phase took hold, the study also addressed the following sub-questions:

- 1) What is/are FNP's primary task/s?
- 2) How does society's treatment and positioning of teenage parents play out within the FNP model?
- 3) What is the impact of austerity and managerialism on the FNP model?
- 4) What are the links between the psycho-social task involved in being a teenage/young parent and the operationalisation of the FNP model?
- 5) What are the conceptualisations of teenage/young parents within policy frameworks and how do these interact with conceptualisations of teenage parents within the FNP model? How are both of these conceptualisations informed by the lives and views of the teenage parents in this study?
- 6) What are the ethical considerations for clinical practice and policy making in this area?

The iterative study design, described in the Methodology chapter, allowed these questions to emerge over time. They are foregrounded here however to provide a framework for the narrative that follows.

In the remainder of this introductory chapter, I will locate the study within its relevant historical, cultural, political, policy and organisational contexts. Whilst providing helpful knowledge for positioning the study, this chapter also provides a methodological introduction to the thesis by adopting from the outset an interdisciplinary and eclectic approach. This is befitting a study which, as I will demonstrate, cuts across many areas of societal and social policy concerns.

Contextualising the study

FNP arrived in the UK in 2007, when a new focus by the then Labour Government was brought to bear on reducing teenage pregnancy and improving the life chances of teenage parents and their children. The FNP model was designed with an understanding of teenage parenthood as a proxy or a "crude marker for risk" because of its association with social disadvantage (Olds, 2016). From this point of view, teenage parenthood is understood to create an opportunity for working with an easily

identifiable population known for having ‘poor outcomes’ and starting as early as possible – before a child is even born. It therefore represents early intervention in both senses of its meaning: beginning early in the life of a baby and early in the life of a perceived problem. The FNP model aims to prevent poor health and social outcomes by enabling parents to take advantage of their innate evolutionary drive to take care of their children and “achieve what they want in life” (Olds, 2016). The FNP model assumes that young mothers and fathers can, with some help, build close bonds with their babies and develop supportive community networks, and through this process become confident or self-efficacious – to use FNP terminology, in their mothering and fathering role (Rowe, 2015/2016).

The FNP model exists, of course, within a wider social and policy environment. As Lawlor and Shaw (2002), point out, the problematisation, and indeed the categories of ‘teenage pregnancy’ and ‘teenage parenthood’ only arise however within particular social conditions. However, anxiety about the sexual behaviour of young people has such deep historical and cultural roots that to even question the problematisation of teenage parenthood risks being perceived as hopelessly liberal or naïve. Because of this, critics ask whether policy in this area is underpinned by the ideological objectification of teenage parents – as seen in the media, public and social discourses (Duncan *et al.*, 2010; Gillies *et al.*, 2017; Kamp and McSharry, 2018), rather than based on up-to-date research data (SmithBattle, 2018).

Demographic context

The conception rate for under-eighteens in England and Wales is at its lowest since 1969 (Office for National Statistics, 2015, cited in Lau Clayton, 2016, p. 130). However, there are considerable regional differences (Hadley, 2018): the 2015 figures show that in the South-East of England, while there was a conception rate of 20.5 (on average, per 1000 births) for those aged fifteen to seventeen, in the North-East the figure was 30.6. Summarising the data on abortion trends, Hadley (2018) notes that the higher the conception rates in a geographical area, the lower the abortion rates tend to be. Underpinning this picture is research which shows that child poverty and

unemployment are the two area-deprivation indicators with the strongest association with under-18 conception rates (Office for National Statistics, 2014, cited in Hadley, 2018, p. 15) – although there is considerable debate about whether indicators are attributable to teenage parenthood as the cause or as a correlation (Duncan *et al.*, 2010).

Nevertheless, as Cook and Cameron (2015) note, despite the reduction in teenage pregnancy rates, the UK still has the highest rate of teenage pregnancies in Western Europe. In terms of birth and abortion rates, the UK continues to be highest amongst European countries, for example one study found that the birth rate was highest in Scotland, followed by England and Wales (Sedgh *et al.*, 2015). The same study also found that the highest adolescent abortion rates were in England and Wales and Sweden. Ethnicity data for teenage births is not readily available (Hadley, 2018) however estimates from the 2001 Census and the information gathered through the Teenage Parenting Strategy (TPS) indicated that whilst Asian groups are under-represented, some London areas – at the start of the strategy period at least - had higher proportions of Black African and Caribbean young people both giving birth and having abortions.

The image of teenage parenthood includes negative stereotypes of single mothers 'abandoned' by 'feckless' fathers. However, this is not always supported by research: one study found, for example, that 80 per cent of young couples conceived in an ongoing relationship (Gates and Byrom, 2008, cited in Lau Clayton, 2016, p. 130), whilst 39 per cent of fathers in another study lived with the teenage mother during pregnancy (Kiernan, 2005, cited in Lau Clayton, 2016, p. 130). Also, according to the Fatherhood Institute (2011, cited in Lau Clayton, 2016, p. 130), 78 per cent of registrations of babies who are born to teenage mothers include both parents' names. Although this statistic alone does not show fatherhood involvement, set alongside the other studies and that of Fagan *et al.* (2007, cited in Lau Clayton, 2016, p. 130) which found that many young parents go on to marry, it suggests a more complex picture than is espoused in popular culture. Cook and Cameron (2015) summarised the qualitative literature on factors associated with a higher likelihood of becoming a teenage parent in the UK and found

that difficulties at school, poor material circumstances and an unhappy childhood, along with having low expectations and aspirations for the future, were most significant.

Historic and public depictions

Lisa Arai (2009) argues that current responses to young parents must be understood within our cultural history of policing the sexual practices of young people, within which the “fertility of undesirables” (p. 124) has long been the focus of moral anxiety. Despite this, the negative depiction of *teenage* pregnancy and parenthood is a relatively recent phenomenon (Duncan *et al.*, 2010). Its precursor was a concern about so called ‘illegitimacy’, i.e. the birth of a child outside of marriage, rather than the age of the mother. The level of stigma that this carried, even as recent as my own parents’ generation, is well-documented, and traumatic legacies remain. The reverberations of hidden pregnancies, forced or coerced adoptions and the shame and secrets linked to these, carried through generations and are still being felt. Although illegitimacy is no longer ostensibly the ‘problem’, its legacy is the shaming and vilification of today’s teenage parents who are judged using a moral framework that continues to hold considerable symbolic societal power (Arai, 2009).

A special exhibition entitled *The Fallen Woman* at The Foundling Museum (2018) in 2015, illustrated the significance of illegitimate birth, well into the twentieth century. The museum is dedicated to documenting the history of the Foundling Hospital, which from 1741 to 1954, provided a home for the first-born babies of unmarried mothers. The exhibition demonstrates how a woman petitioning the hospital to have her baby fostered had to meet strict moral criteria for her request to be considered. Echoing the concept of the ‘deserving’ or ‘undeserving poor’ (Gans, 1995) - the exhibition shows how women were required to provide evidence - letters from ‘respectable’ members of society - which proved they were not to ‘blame’ but were respectable women who had ‘fallen’ (The Foundling Museum, 2018). The ‘fallen woman’ was a common image in the cultural representations of the time – depicted in art and literature as a woman whose sexual behaviour had caused her to become a social

outcast. The Foundling Hospital offered her the opportunity to re-join respectable society and avoid infanticide (a fairly common practice of the time), but to do so, she had to demonstrate (Fearnley, 2018) that she was a victim rather than a willing participant in her own downfall.

Powerful societal norms and cultural associations, especially those with moral and religious overtones are not easily shed, even when on the surface at least there might be far fewer societal rules today governing sexual conduct (Fearnley, 2018). With the so-called sexual revolution of the 1960s and beyond, the expectations around marriage have greatly relaxed. However, something of the stigma and shame levied on and expected of unmarried mothers in the past, including the need to morally justify their behaviour, has been transferred to today's teenage parents. Thinking psycho-socially, I would suggest that the 'othering' of teenage parents is an example of an unconscious societal defence. Perhaps, for example, as with unwed mothers of the past, today's young parents ignite fear - about the cost of their dependency which could lead to societal breakdown if there are too many of 'them' compared to the hard-working 'us'. On a deeper level, there may also be a fear of 'unbridled' sexual activity. Teenage parents might also ignite unconscious anger at their apparent abdication of the modernisation self-as-project (McRobbie 2007, cited in Arai, 2009, p. 119) 'slow' route to a work-oriented adulthood, which involves acceptance of individual economic responsibility (Alldred and David, 2010). Or they could ignite envy, at their blatant defiance of social expectations – like the undeserving 'prodigal son' assuming an entitlement to welfare support which it is assumed they have never, and may never, contribute to. The reduction in teenage pregnancy across the population in general may have led to an intensification of these responses to young parents, who now 'stand out' even more than they did (Arai, 2009). This is all in the context of a media whose emotive headlines about 'epidemics' of births to teenagers are surely answerable for the findings of a MORI poll in 2008 in which 81% of people said they thought that teenage pregnancy was increasing (Duncan *et al.*, 2010) despite forty years of consistent reduction. Therefore, although we now live in an ostensibly much more liberal society than the one which required women to petition the Foundling Hospital, today's young mothers and fathers continue to need to 'prove' their

acceptability and 'respectability' (Formby *et al.*, 2010). Now, however, on the surface at least, this takes place within a neoliberal framework rather than a moral-religious one.

Political responses to teenage pregnancy and parenthood

Not surprisingly, political reactions and policy frameworks around teenage parenting mirror cultural and societal responses, so that we see young parents oscillate between being either pitied (Dodds, 2009) or blamed (Macvarish and Billings, 2010). As Levitas notes:

Interrelated concepts act together as a matrix through which we understand the social world. As this matrix structures our understanding, so it in turn governs the paths of action which appear to be open to us. (1998, p. 3 cited in Dodds, 2009, p. 503)

In this way, the historic framing of unwed mothers, popular depictions of teenage parents and political trends intersect with one another to shape policy responses and the services available to young parents. This explains why interventions for young parents intensified even as the birth rates of teenage parents reduced (Arai, 2009). Certain anxieties about the ability of parents to bring up the next generation; the vulnerability of contemporary childhood; worries about social and moral decline; and the need to legitimise state involvement all lent "particular power to the problematisation of younger motherhood" (Macvarish and Billings, 2010, p. 66). This intensification included new ways of depicting the 'problem' and new research interests around this area. Teenage parenthood therefore stands out as a policy issue due to it "touching so many raw, social nerves" which include "youthful sexuality, absent fathers, welfare dependency, problem neighbourhoods" (Arai, 2009, p. 110). This is traced back to longstanding anxieties about the behaviour of the working classes, particularly concerning fertility and intergenerational poverty which links to broader concerns about the 'underclass' whose irresponsibility, criminality, large families and welfare support "set off every trigger point of fear and desire" (Young, 2007, p. 77, cited in Arai, 2009, p. 116).

In line with the cultural and public views outlined above, in the 1980s the Conservative focus was not teenage mothers per se, but young *single* mothers (Arai, 2009), who, due to their perceived moral promiscuity and ‘sponging’ of welfare benefits, offended the idea of ‘traditional’ family values. From these punitive narratives, there emerged under New Labour, with the advent of the Social Exclusion Unit (SEU) in 1999, a new conceptualisation which recast teenage mothers as “more sinn’d against than sinning” (*King Lear*, 3.2.57-60). The new thinking attempted to acknowledge the ‘issue’ as both behavioural and structurally driven, whilst holding on to the idea of intergenerational deprivation. Arai (2009, p. 112), draws on Schnieder and Ingram’s analysis (1993) of how target populations are positioned, and the interplay between this and their relative political power, to show how under New Labour the issue of youthful fertility shifted within policy discourse from ‘deviancy’ to ‘dependency’. As dependants, teenage mothers should now be responded to as “vulnerable and in need of assistance, especially assistance to do the ‘right thing’ and make the ‘right choices’” (Carabine, 2007; McRobbie, 2007, cited in Arai, 2009, p. 119), which brought with it both more services and more scrutiny – particularly for working class mothers (Arai, 2009). This new focus coalesced around the TPS, under the auspices of the SEU.

The TPS was the UK Government’s response to its “shameful record” (Tony Blair, cited in Duncan, 2007, p. 4) of higher levels of teenage childbearing in the UK compared to the rest of Europe. Hadley (2018) points out that the reason for this contrast is widely attributed to macro societal differences. For example, in those societies with lower teenage birth rates than the UK, there was found to be greater gender and income equality; more realistic societal norms about young people’s sexuality; and readily available sex and relationship education along with contraception and support services. The TPS however, attempted to align the UK with the rest of Europe in terms of outcomes by focusing on teenage motherhood as a risk factor, rather than addressing macro societal factors. The omission of the word ‘parenting’ from the strategy itself points to a focus on the eventual eradication of teenage parents, either through the prevention of conception during teen years or through the longer-term vision of reducing the supposed “intergenerational” (Askew, 2018, p.x) features of

teenage parenthood. Therefore, under New Labour there was an attempt to provide more resources to educate teenagers away from parenthood.

Over a ten-year period – which ended when the Coalition Government came to power in 2010 – the TPS oversaw a drop in teenage pregnancy conceptions in England by 34% (Royal College of Midwives, 2013) and an increase in the proportion of teenage parents in education, employment and training (Cook and Cameron, 2015). Nevertheless, Robling *et al.*, (2015) highlight that teenage mothers continue to face “individual, social and economic” (p.1) challenges. Citing four studies from health and child development perspectives, they claim that these challenges can negatively affect the children of teenage parents and interrupt teenage mothers’ long-term socio-economic stability. They also assert that there is evidence to suggest that early intervention with young mothers can enhance their life chances and those of their children, citing a further four studies. Although, as I discuss in the literature review, the correlation between teenage parenting and poor outcomes is contested (Duncan *et al.*, 2010), the Teenage Pregnancy Knowledge Exchange at the University of Bedfordshire continues the work of the TPS. It is underpinned by the belief that young parents and their children are ‘at risk’ in terms of their developmental and economic outcomes (Royal College Midwives, 2013).

Overall, the TPS, according to Carabine (2007, cited in Arai, 2009), espoused three main narratives about teenage parents, which coalesce with some of FNP’s approaches. The narratives are “risk management through knowledge acquisition” (p. 119), analogous to the ‘technical/educational’ perspective – arguably seen in the use of a manualised programme within the FNP model. The second is “shifting blame” (p. 119), whereby society, not the individual, is blamed for teenage pregnancy – traceable perhaps in the role of systems and ecological theory within the FNP model. Thirdly the advancement of “constituting knowing active welfare citizens” (p. 119), such as the encouragement of agency and economic responsibility by teenagers – which mirrors the role of self-efficacy within the FNP model. This approach was framed as supporting the UK’s commitment to meeting the Sustainable Development Goals by 2030. The Coalition Government, which formed in 2010, decided to end the stand-

alone TPS, handing over responsibility for reducing pregnancy and improving outcomes for young people to local government, under the Public Health Outcomes Framework. This involved the expectations around the narrowing of health and education inequalities and reducing child poverty (Hadley, 2018). FNP outcomes are measured against this framework, including increases in breastfeeding and a reduction in maternal smoking and hospital admissions caused by unintentional and deliberate injuries to under 5s.

According to Arai (2009), moral and social framings of teenage motherhood as a problem are subordinate to the economic imperative of cost savings to the public purse. Likewise, whilst the FNP model seems to coalesce within certain aspects of the TPS, and with current policy, it was not originally designed for it and has its own organisational history and vision.

FNP history and structure

The Family Nurse Partnership began in the 1970s in the USA, under the direction of Professor David Olds, who was motivated by a desire to harness disadvantaged parents' natural caregiving tendencies (Rowe, 2013) to bring about better outcomes for babies and parents. The model he designed underwent three Randomised Control Trials (RCTs) (Olds, 1986; Kitzman *et al.*, 1997) to test the potential of an intervention which began, as noted previously, 'early' in two senses – from sixteen weeks gestation and with parents under 19 years old, with the vision statement 'Changing the world one baby at a time'.

Positive outcomes from the US research led to the programme's international reputation as having a strong and credible evidence base (FNP, 2016). Part of this reputation is linked to how replication of the model is carefully considered, so much so that each new site must be licensed to run the programme and must ensure fidelity in both implementation and intervention to the Nurse Family Partnership, as it is known in the USA (Appendix A). The requirements of the license (which comes from the University of Colorado and overseen in the UK by Public Health England (PHE)) includes

training family nurses to deliver a structured programme. It was on the strength of the success of the American programme that the UK Government decided to pilot the programme in the UK in 2007. Ten sites were set up, followed by another 70, the evaluations of which identified good evidence for the potential of implementing FNP within universal services in England and a commitment by the UK Government to a major expansion of the programme (Department of Health (DoH), 2012). This led to rapid and energetic growth in FNP sites, evaluated by a large-scale independent RCT (Robling *et al.*, 2015). It was a “hugely significant policy-initiative” (Ferguson, 2016, p. 100) considering the speed and scale of growth, in a climate in which funding for other longer-term, relational, early-years and early-intervention services was being scaled back in favour shorter term initiatives (e.g. the rise of CBT over long-term psychotherapy; or the closure of local authority Play Services). However, FNP’s strong evidence-base and targeted approach enabled it to coalesce sufficiently with government policy to secure its expansion.

To facilitate the growth, and with fidelity to the original model in mind, the DoH and PHE jointly commissioned the Tavistock and Portman NHS Foundation Trust, the Social Research Unit at Dartington, and Impetus – a Private Equity Foundation, to lead and host the FNP NU. Rather than directly employing local FNP teams, the NU’s role is to provide strategic leadership, research, clinical guidance and develop the programme. Under its leadership, many new sites were set up between 2011 and 2015 – each one commissioned and procured under local arrangements and delivered by, in the main, a local NHS Trust provider. At its height, some 130 sites were in existence. As the FNP infrastructure was embedded and the planned expansion took place, there was much optimism and excitement around this new intervention, which offered a distinctively different approach to working with teenage parents (DoH, 2012).

Recent challenges

When I began this study in February 2016, the NU was in a time of transition: from a decade of energetic pioneering to a period of reflection and consolidation - precipitated by several challenges. One of these was the transfer, in October 2015, of

0-5 children's public health commissioning arrangements from NHS England to local authorities (DoH, 2015). Although potentially creating new opportunities, it also disrupted carefully developed relationships at the commissioner/provider level and allowed for the possibility of cheaper pseudo-FNP services to be developed. This increased the pressure on the NU's 'Service Development Leads' – those responsible for maintaining commissioning relationships at the local level – to promote the unique value of retaining FNP in a newly competitive environment.

Another challenging factor was the publication of the first stage of the UK's RCT into FNP, 'Building Blocks' (Robling *et al.*, 2015). To the surprise of many, it concluded that FNP provided 'no benefit' (compared with usually provided services) in the outcome areas of smoking cessation, birth weight, subsequent pregnancy and A&E/hospital admissions (see Public Health Outcomes Framework above). The trial did find the FNP programme showed some benefits for early child development, and, significantly for this study, was consistent with a Canadian study (Kutz Landy *et al.*, 2012 cited in Mason, 2015/2016, p. 7) in finding that "it was the trusted relationship with the family nurse that was most valued, and the expert support she was able to provide as a result of that relationship" (Mason, 2015/2016, p. 7). Despite this, the overall findings were inevitably disappointing for FNP (Nolan, 2015/2016) and have led to further uncertainty about how they will be interpreted by commissioners and greater levels of 'survival anxiety' (Cooper, 2018). The second stage of the trial is due to be published in 2019. The fact that this research was published just as mine began, impacted its existential and conceptual nature. Approaching sites to take part in the research, I was acutely aware of their sensitivities around the issue of academic research. I sensed their relief when I explained my intention to explore rather than evaluate, and to use qualitative methods to draw on diverse knowledge held within the system.

Both the RCT findings and new commissioning arrangements interplay with the third challenging factor, which was the implications of the UK Government's austerity policy, within which budgets for delivering services have been drastically reduced. It has led to the shrinking of support services that family nurses would historically have partnered with at a local level. It also saw the decommissioning of a small number of FNP sites, by

local authorities under pressure to justify the allocation of resources, particularly preventative services like FNP which direct intensive resources to a target population (Franklin *et al.*, 2017). Inevitably, this created a sense of vulnerability, pressure and uncertainty within the FNP system. During the spring of 2016, the FNP NU engaged in a series of reflective consultation exercises with a range of stakeholders to inform their response to these challenges. Sites were given some flexibility on the eligibility criteria for the first time and 'FNP Next Steps' was launched which involves a rapid cycle testing project of adaptations to the intervention model, supported by Dartington Service Design Lab. The NU's aim is now to use the learning from this to continue to fine-tune the FNP programme for the UK context, whilst a similar process is also taking place within the USA (FNP, 2018). The *FNP ADAPT Interim Report* (FNP, 2018) highlights how the FNP model's reliance on the policy context for local implementation, as well as the workforce's fidelity to the current core model, are two of the challenges faced. Despite this, the NU found that it is possible to be flexible with the eligibility criteria to reach a wider client group and find new ways of personalising the FNP model for each client. Their focus is on developing ways to intentionally share the learning from FNP across the wider system, and indeed this study's interest in understanding the operationalization of the FNP model, and unpicking its phenomenological and existential meanings, feeds directly into this broader agenda.

During this time, FNP NU also underwent significant restructuring in response to a reduction in its budget. In the spring of 2019, it announced that it would be transitioning towards being based within PHE, to be part of the *1000 Days* initiative (Great Britain. House of Commons: Health and Social Care Committee, 2019) which focuses on early intervention in the life of a child.

Outlining the FNP model

FNP is a health led initiative – underpinned by its use of registered nurses to deliver the programme. It has strong links with universal health services for young families and sits within the Healthy Child Programme within England (DoH, 2009). Family nurses' closest professional colleagues are therefore midwifery and health visiting and indeed

many family nurses have previously practiced in these roles (Robinson *et al.*, 2013). The FNP model is distinctive from universal provision in both clinical practice and implementation – for example, family nurses have a caseload of up to 25 (DoH, 2012) compared to Health Visitors who, in some areas, hold as many as 800 children (Campbell, 2018). Family nurses receive more intensive training and supervision than colleagues in these related professions and are remunerated at a banding comparable to a team manager within health visiting. This sometimes gives rise to envy (DoH, 2012) and tensions within the system locally.

The FNP model was designed to draw on three main theoretical ideas, namely Human Ecology (Bronfenbrenner, 1979); Attachment Theory (Bowlby, 1969) and Self-Efficacy (Bandura, 1997) (FNP, 2014). It involves regular home visiting by a family nurse to a mother for over two years, in which supportive relationships between family nurses and clients provide the platform for the delivery of a manualised psycho-educational curriculum (DOH, 2012; Rowe, 2015/2016). They cover a variety of topics, including child development, healthy adult relationships, planning for future education and promoting health/well-being. Within the FNP model, relationships – which are “purposeful, respectful, empathetic” (Rowe, 2015/2016) are understood to be an important vehicle for the application of the programme, and also a significant part of the intervention itself (Rowe and Byrne, 2014). Family nurses are therefore trained to deploy a strengths-based approach to bringing about change in the lives of their clients, drawing on Motivational Interviewing techniques and developing the necessary communication skills (Ferguson and Gates, 2015). Family nurses are encouraged to involve wider family members, including the baby’s father and grandmother as much as possible, and to link clients in with the local support services (Olds, 2016). There are structures within the model for gaining regular client feedback, and participation from clients is a feature of interview panels and other forums where FNP give an account of their work (FNP, 2018). Client representatives are invited to be part of the local FNP Advisory Board, for example – a multi-agency group often chaired by the commissioner and attended by the site supervisor, Provider Lead (usually a senior leader in the NHS hosting organisation), a representative from the NU and other local relevant stakeholders from social care, health and early years.

A family nurse's role involves delivering the FNP programme – e.g. the manual containing 'facilitators'. These are resource handouts on various topics covering a broad curriculum (DoH, 2012). The programme structures the topics according to the stage of life of the client and her baby so that there is a topic and corresponding facilitator for each of the 64 visits which take place over the course of the intervention. There are interactive exercises within these to generate conversations and engage clients in active learning. Family nurses are also expected to use specific clinical tools for observing, assessing and supporting attachment and parenting skills (Cook *et al.*, 2016). These are known under the acronyms PIPE (Partners in Parenting Education) and DANCE (Dyadic Assessment of Naturalist Caregiver Experience). Nurses self-assess their own performance and are given feedback from their supervisor about their use of these tools. In addition, family nurses undertake a range of other health-related tasks including weighing babies and undertaking regular Ages and Stages Questionnaire (ASQ) scores.

At the implementation level, a core element of the model is a support structure for nurses. This includes weekly case-load supervision with the FNP supervisor, monthly group supervision with an external partner from clinical psychology or safeguarding nursing alternately (DoH, 2012) and a weekly team meeting. It is believed that nurses' experience of containment provided by supervisors increases their capacity to provide it for their clients and that they in turn, are more likely to offer this to their babies (Nursing Times, 2016). This belief also runs through the clinical training programme received by nurses and supervisors, so that pedagogical methods are chosen which allow trainers to model the FNP approach (Rowe, 2015/2016). As the DoH note in their review of the training received by the first 10 pilot sites "the attention had clearly buoyed the FN teams up; and it is a direct modelling of the attitude they use in their relationship with their clients: positive and inspirational, expecting the best and believing that the child and his or family will achieve it" (2012, p. 43, *ibid.*). The FNP model also includes the aspiration that adopting a strengths-based, relational approach with external partners can change their way of working to be more in line with FNPs, thus transmitting the model 'horizontally' as well as 'vertically' through the

organisational system (Rowe and O'Byrne, 2014). This is represented by the idea of a 'golden thread' (a colloquialism within FNP) which runs through the organisation, so that behaviours, values and attitudes practiced by nurses at the micro level can be 'scaled up' at other system levels, to similar effect.

Nurses typically work in small teams of between four and eight nurses, with one full-time administrative support. The workforce is overwhelmingly female with a modal age of 40 to 49 (Robinson *et al.*, 2013). Although they interact with other health services such as midwifery and sexual health, family nurses also work closely with social care, due to the vulnerability of their client group. Family nurses have considerable involvement in safeguarding processes (Ferguson, 2016) and there is arguably significant cross over with the role of a family nurse and relationship-based family support social work. However, the family nurse's protected long-term caseload, the structured recognition of the emotional impact of the work and recognition of the interrelated needs of parents and children, are features that set it apart from dominant social work practice (Featherstone, White and Morris, 2014). Here, New Public Management (NPM), has shifted practice from relationship-based towards bureaucratic systems, with routinized interventions and management of risk (Trevithick, 2014), meaning that FNP's clinical approach often contrasts with those of professionals working with the same client group. This is highly relevant in the context of a study interested in looking at the distinctive nature of the FNP approach and the effects of this within diverse systems.

Thesis structure

The thesis is structured in such a way as to provide a logical narrative of the study. The beginning chapters provide contextual information about the policy and practice issues, conceptual frameworks and theoretical knowledge relevant to the study. They also explain how the study came about and why it was executed in the way that it was. Together, these provide a justification and introduction to the latter half of the thesis which contains my contribution to new knowledge. Within these chapters, the analysed findings are presented, leading to a theoretical discussion of the main ideas

which came out of this process. The thesis then pulls together the learning from the preceding chapters into an overview of the main implications, for FNP, social policy and the academy.

A more detailed introduction to the thesis chapters is provided below:

The **literature review** draws on a diverse range of material to make the case for the multi-dimensional nature of this study. The review demonstrates that whilst there is much supportive scholarship for this study, there is also a distinct absence of directly similar work, either in terms of subject matter or methodology. The literature drawn on in this chapter sits alongside the scholarship referenced in this chapter, which speaks both to the broader societal issues in which this study is located and to specific FNP related policy and research to date.

The literature review is followed by the **methodology** chapter. It discusses the initial conceptualisation of the study, explaining how psycho-social theories, such as social and organisational defences against anxiety, can provide a 'beneath the surface' lens on the FNP model. In particular, Menzies-Lyth's (1959) seminal nursing study, which employs observational methods, was influential in the decision to include ethnographic methods alongside other psycho-social research tools. The chapter also explains how a systemic framework in the study design facilitates thinking about activity across micro, meso and macro levels, providing multi-factorial perspectives on the FNP model and advancing subject and methodological knowledge.

There are then three **findings** chapters. The first findings chapter relates to the data from and about FNP clients. The second, data from and about family nurses. The third chapter presents the data from and about the wider organisational context - including the views of supervisors, stakeholders and NU leaderships. With direct quotations taken from ethnographic observations, focus groups and interviews, the data set shows how the FNP model produces varied reactions and interpretations, often influenced by its local implementational environment. The data also highlights the

importance of continually holding in mind the hostility and stigma faced by teenage parents when interpreting the nature and meaning of FNP model.

Diverse responses to the FNP model and the experiences of teenage parents are then taken up within the **discussions** chapter. Looking firstly at the nature of teenage pregnancy, I discuss how this area of work gives rise to particular challenges in terms of holding a balanced, ethical position in which contrasting feelings, ideas and values can be integrated. The focus then turns to how these paradoxes play out within the FNP system by critically exploring the ‘problem’ that FNP is trying to address through a discussion of the ‘primary task/s’, the ethical problems involved with this and the competing and complex accountability demands at play. Using social policy, cultural theory, systemic, and psycho-social lenses, the discussion builds the case for balancing the individualistic elements of the model with collectivist/systemic approaches.

The final **implications** chapter takes the ideas from the findings and discussion chapters, to formulate potential avenues for future development. These focus on the NU’s remit and wider methodological implications for social policy and organisational scholarship.

Conclusion

The FNP approach is to seek to avoid the splitting narratives of blame or pity that surround the issue of teenage parents, by focusing on their potential for positive outcomes. It often feels itself to be “swimming against the tide” (Swarbrick, 2016) of political, cultural and societal attitudes which are not always straightforward or consciously held. That FNP is interpreted by some as reinforcing, rather than resisting, dominant narratives about teenage parents – as explored in the next chapter - serves to highlight the complexity of this controversial area of policy and practice. Within this context, holding an integrative position can be hard to maintain. In the first few months of the study, for example, I was struck by how passionately everyone spoke about the role of relationships within the FNP model, and how little, in contrast, they spoke about its other features, such as the manualised educational programme. The

very high value placed on relationships appeared to be something of an organisational mythology, shared passionately through informal narratives. It seemed to occupy a very different place in hearts and minds to the more 'official' descriptions of what family nurses do. This study seeks to address this by translating practice wisdom into empirical knowledge and in so doing formalising understandings of the role of relationships in the FNP model. It also explores how such divisions and polarisations arise and the generative potential of gaining a better understanding of them, in the context of the lived experiences of teenage parents.

Chapter 2: Literature Review

Introduction

Reviewing the relevant literature for this study posed challenges relating to its niche character. It seemed to have potentially hundreds of ‘cousins’ but no direct ‘siblings’ to work with. The FNP model, as an organisational phenomenon and as a research subject, is something of an outlier. As I describe in my methodology, it was hard to find a good fit for FNP within the NHS ethical permissions system due to it being a national programme under licence and yet delivered in decentralised locally commissioned sites. It can be viewed as both a single organisation and a collection of organisations, or perhaps like a franchise which is embedded within an established institution (the NHS), although the fact that there are a small number of non-NHS providers further complicates this already quite complicated description. Other aspects of its uniqueness lie in the fact that whilst FNP delivers community-based nursing, their clients are not diagnosed with an illness and the care provided does not fit into a medicalised model of ‘treatment’ to ‘patients’. Indeed, they are not ‘patients’ at all, but ‘clients’. Family nurse work crosses health disciplines - such as midwifery, health visiting and mental health nursing - with social care disciplines - such as social pedagogy, advocacy, family support and social work. Alongside both of these are counselling or therapeutic practices, which could be thought to straddle health and social care disciplines. The space provided within the FNP model for long-term relationships; the intentional attempt to alleviate the emotional aspects of the work through the provision of supervision; and the principle of focusing on strengths rather than deficits are all, I would argue, features that make the FNP model unusual in modern social care and health organisations. These features contributed to my difficulty in narrowing down the related literature from which to draw.

There was also the challenge of finding methodologically relevant material. Whilst there are ethnographic studies of organisations, workplace and practice orientated literature, there are few which involve both those who deliver services and those who use services as equal participants to explore meanings and build conceptual

understandings. In the field of psychoanalytic organisational studies, most examples are either entirely theoretical in focus or, where there are applied examples, data is derived from professional consultation rather than through empirical academic research, limiting their applicability to this research to some extent. The limited availability of directly relevant material to draw on however, underlines the knowledge contribution which this study makes and means that it has the potential to speak to numerous emerging research areas.

To build the case for the relevance of this research I focus on four main areas of literature, which are: 1) Contextualising literature on the lives and experiences of mother and fathers who are young; 2) Critical policy research relating to young pregnant and parenting teenagers; 3) Related models and interventions, including some comparators in the field of early years and early intervention work and 4) psycho-social literature which a) defines the conceptualisation of relationships that I draw upon, and b) contextualises how this research relates to the field of psycho-analytic organisational studies. Where possible I have prioritised health, nursing or social work focused studies, in acknowledgement of the multidisciplinary nature of the FNP role and this study. In response to the eclectic nature of the types of literature drawn on, I employed an iterative approach to finding relevant material. As well as using traditional search methods through library catalogue databases (such as JSTOR, Wiley, Sage) I also followed up promising-sounding references at the end of papers, drew on my social work practice networks and took up recommendations from my supervisors.

The presentation and cataloguing of literature mirror my wider methodological approach of privileging quality and depth over quantity. Whilst the latter might have allowed for the inclusion of a greater number of studies, I believed that the chosen approach supports a rich conceptual understanding of the relevant fields of study and is therefore an appropriate introduction to the chapters which follow.

Contextualising literature

Young mothers

FNP work with first-time mothers and fathers - although the latter may not necessarily be 'first-time', young or the biological father of the baby of the client. Whilst family nurses hold fathers in mind, the eligibility for FNP services is determined by the mother, and she is thought of as the FNP client. I will therefore begin with a focus on the literature about young mothers, followed by an overview of the research on young fathers. Before doing this however, I acknowledge briefly the larger body of research concerned with motherhood and the maternal, to underline the socially constructed nature of the category of 'teenage' or 'young' mother and to recognise that mothers who are younger than the average population are also implicated and included within the wider diverse scholarship on this topic.

Whilst age is significant for how women experience motherhood, due to its link to socio-economic opportunities (Thomson *et al.*, 2011), there are also features of motherhood that can affect women of any age. Women of all ages for example, take primary responsibility for childcare and bear the financial responsibility (Breitenback, 2006; Doucet 2006 cited in Thomson *et al.*, 2011, p. 4). Feminist scholarship which highlights issues such as this has, since the 1950s, dominated academic work on motherhood. They have focused on the oppressive elements of maternal and feminine ideals (Rich, 1997; Chodorow, 1978; Ruddick, 1980 cited in Thomson *et al.*, 2011, p. 5); the legal, state and medical regulation of mothers (Pheonix *et al.*, 1991; Lewis, 1992' Smart 1992 cited in Thomson *et al.*, 2011, p. 5); from a psychoanalytic and sociological position, have been accounts of maternal ambivalence "which acknowledged the subjective force of 'being loved so much and blamed so intensely" (Parker, 1996; Smart, 1996 in Thomson *et al.*, 2011, p. 5); the transformations of the private sphere of motherhood through global capitalism (Hays, 1996; Hochschild, 1997 in Thomson *et al.*, 2011, p. 5); and in more recent times an interest in how maternal relations are shaped by intergenerational dynamics (Bjerrum Neilsen and Rudberg, 2000; Lawler, 2000; Brannen *et al.*, 2004;

O'Connor, 2011; Everingham *et al.*, 2007; Baraister, 2009; Woodward and Woodward, 2009 in Thomson *et al.*, 2011, p. 5). Of relevance to this study is an interest in how phenomenologically framed contemporary scholarship can disrupt the positioning of motherhood as an "empty subject" within psychological and psychoanalytic theory, so that:

Rather than reading the accounts of mothers back to universal models of pathology and development, we are invited to consider how their experiences push them into territory that confounds their expectations and those of our theories. (Thomson *et al.*, 2011, p. 6)

This interpretative mindset influenced this study by validating my approach to analysing the phenomenological experiences of young mothers in the light of teenage parenting policy and encouraging me to consider the potential disruption that this type of linking could bring about.

Having an awareness of the broader scholarship on motherhood also encouraged me to connect the experiences of young mothers with those of older mothers, in order not to uncritically attribute particular experiences or feelings to age. For example, FNP clients, as well as being young are also *first-time* mothers and undergo identity transitions through motherhood seen across the age range (Hollway, 2015). Choi *et al.* (2005) for example found that first-time mothers are often subject to significant cultural and social expectations as reflected in their study's title, a telling quote from a participant: "Supermum, Superwife and Supereverything". This alerted me how teenage mothers are exposed to, and therefore might internalise, the same cultural 'messages' as mothers of other ages, and feel the same pressure to comply with an "ideology of motherhood" (Choi *et al.*, 2005). The research in this area highlights how mothers feel inadequate and guilty, but with particular features linked to their age such as, for the young, greater professional scrutiny (Featherstone *et al.*, 2018) and disapproval (Hollway, 2015). Additionally, the high value that mothers place on peer support for coping with transition processes (Choi *et al.*, 2005; Hollway, 2015) can be set alongside data

about the diminishing number of young parents to highlight the particular issues that younger parents face accessing peer support (Coleman and Cater, 2006).

Through this literature, I became aware of the particular burden of internal 'shoring up' that young mothers are expected to undertake. Younger mothers are asked to establish their moral agency (Thomson *et al.*, 2011) in the face of real or anticipated judgement and, as noted above, often without a readily available peer-group to co-construct feelings of being 'good enough' (Winnicott, 1971) for their task. During the fieldwork I tried to stay alive to these issues and how they might play out. As the methodology chapter explains, I thought carefully about how to minimise the possibility that I might be seen as an intimidating judgemental presence to whom FNP client would feel an impulse to give an account of themselves. However, I also acknowledge the fact that I am likely to be socially constructed as a 'middle-class' agent of the state within the minds of clients, potentially enlivening persecutory or specific forms of performative impulses. I held this in mind during the analytic stage and remained reflective throughout about the power dynamics within the fieldwork gathering process.

Just as the literature on first-time parents provides helpful learning for thinking about teenage motherhood, the small amount of literature on the experiences of mothers who use child-welfare services is also informative to this study. McGhee and Waterhouse's (2017) conceptual analysis of a single case study of a mother involved in child protection processes stands out in term of relevance, due to its methodological and subject crossovers. The paper questions the way that welfare involved mothers are uncritically exposed to:

A theoretical conception of a child's developmental needs and life opportunities untethered from the vagaries of social and economic constraints. The actual conditions of raising children in low-wage or benefit-dependent households become secondary to a cultural test of successful motherhood. (p. 1653)

Their methodological approach of listening closely to the narrations of mothers who use services enabled the authors to consider the "personhood" of mothers and their

everyday struggles against under privilege, allowing these accounts to complicate the dominant view expounded within policy or the media. This inspired how I approached issues of justice and representation concerning how young mothers negotiate participation and agency within institutions.

Returning to the literature specifically relating to young mothers, the message from qualitative scholarship is caution against assuming fixed notions of homogeneity. For example, a young mother in Thomson *et al.* (2011)'s study reported how motherhood had led her to new educational opportunities, rather than heralding the foreclosure of such possibilities. Likewise, class is also a significant factor in determining how young women experience young motherhood. While some middle class young mothers experience it as a disruption to educational progress, working class young mothers - who are in the majority and who are more likely to be disaffected from school (Allred and David, 2010) - are less likely to view pregnancy in rupturing terms (Walkerdine *et al.*, 2001). The significant message to come out of qualitative studies is that there is an 'economy of values' (Thomson *et al.*, 2011) within which becoming a teenage parent can seem reasonable to some young people and disastrous to others (SmithBattle, 2018). This knowledge was important in shaping my interest in understanding how teenage pregnancy and parenthood has been conceptualised as a singular issue within policy frameworks, and how this affects corresponding intervention responses.

The literature addressing young mothers' experiences of stigma, although under researched (SmithBattle, 2013), paints a consistent picture of discrimination within Western countries. Extant studies - which include those with self-reporting and observational research methods - demonstrate how the hostility faced by young mothers emanates from a range of sources including the media, strangers in public, and health and education professionals (SmithBattle, 2013), leading to "feelings of resentment, fear, shame, anger, and worthlessness" (Yardley, 2008, cited in SmithBattle, 2013, p. 238). One of the most recent UK based empirical studies developed the idea of the "inferiorisation" (Fearnley, 2018, p. 64) of young mothers to describe a process of day-to-day discriminatory experiences. These include being frequently shouted at, sworn at and called names; treated as if they were not there by

professionals; and receiving disparaging ‘looks’ of disgust or disapproval by strangers. The study attributes this to perceptions about young mothers’ sexual (mis)conduct and assumptions that they are single parents. It echoes other scholarship in this area (e.g. Duncan *et al.*, 2010) by drawing attention to the contrast between the generalised images and assumptions of ‘teenage parenthood’ within cultural, media and political discourses, and the lack of regard for the diverse voices of the young women implicated in these discourses. These studies led me to consider the extent to which I may have internalised received ideas about teenage motherhood unknowingly and challenged me to be alert to the unconscious judgements I might hold. My decision to include reflective methods in my study design was intended to allow for self-examination in this area. Also, this literature supported and justified the qualitative, relationships-based, open research methods I chose, which, I hoped would allow for individualised narratives to be shared.

I was also influenced by how qualitative studies informed by the voices of teenage mothers, have led to contextual and systemic understandings of this ‘issue’ (Kamp and McSharry, 2018). One such re-framing is that rather than teenage parenthood being equated with ‘risk’ posed by a young mother to her child - and by inference society (Macvarish, 2010, cited in Fearnley, 2018, p. 66) - young parents could be seen to be *put at risk* by the stigmatising environment in which they parent, as maintained by political discourse and professional practice (Arai, 2009; Duncan *et al.*, 2010; Yardley, 2008). Such conceptualisations of the dynamic interplay between a discriminatory environment and the experiences of young mothers were very influential within my study, providing a segue into understanding the meanings that young parents gave to their relationships with their family nurse.

Young fathers

The literature addressing young fathers is minimal. That which does exist draws from large-scale studies, meaning that qualitative studies are very rare (Lau Clayton, 2016). The extant research draws attention to how policy discourses position young fathers as “absent, no use, criminal and socially excluded” (Lau Clayton, 2016, p. 129), in contrast to the more vulnerable/immoral depictions of

young women. Contrary to this image, a summary of current empirical knowledge shows some young fathers with high levels of involvement in the lives of their children or when not involved, reported associated distress (Osborn, 2008, cited in Lau Clayton, 2016, p. 132). Lack of interest in their children was “associated with financial insecurity or uncertainty over the skills required for childcare, particularly for babies and younger children” (Lau Clayton, 2016), highlighting both the barriers and potential opportunities for the further involvement of young fathers (Duncan *et al.*, 2010). Additional challenges for young fathers in taking up an active parental role are the familial context into which a baby is born. The negotiation of complex intergenerational maternal ‘gatekeepers’ (Neale and Lau Clayton, 2011 cited in Lau Clayton, 2016, p. 129) for example, may require a level of confidence and skill young men may not have had opportunity to acquire.

Although research suggests that the involvement of young fathers by professionals at an early stage is likely to increase their future involvement (Duncan, 2007), several studies show health and social care services tending to regard them as uninvolved and threatening (Page *et al.*, 2008; Featherstone *et al.*, 2007; Maxwell *et al.*, 2012; Featherstone, 2013; cited in Lau Clayton, 2016, p. 135). This can become a vicious circle in which ‘hard to reach’ fathers absent themselves from services as a defence against the dominant view they expect to find there (Featherstone *et al.*, 2007, cited in Lau Clayton 2016, p. 135). My experience of working in social care parenting settings coalesces with the idea that discourses of absence and risk are “ingrained within official orthodoxies and popular thinking on young parenthood” (Maxwell *et al.*, 2012, cited in Lau Clayton, 2016, p. 135). During the execution of this study therefore, I tried to stay alert to the influence of these orthodoxies, hoping to notice how it played out within the FNP model and to resist inadvertently replicating it myself.

Speaking directly to the question of how young fathers experience FNP is an evaluative and explorative study undertaken for FNP by Ferguson and Gates (2015). This mixed-methods study shows how fathers – along with the mothers with whom they were associated - were characterised as vulnerable due to being

poor, having low educational attainment, out of work, and either involved with or on the edges of criminality. Eleven per cent of their participants had been in Local Authority care. Three quarters lived with their child's mother. Linking in with qualitative scholarship on young mothers, fathers here spoke of how fatherhood had enabled them to mature and take responsibility. Several valued how their family nurse has helped them become more involved, particularly during pregnancy when they had gained knowledge and confidence in parenting skills. The study highlights the multi-dimensional family nurses in supporting a parental couple to communicate and understanding each other through "meaningful professional service-user relationship" (p. 103), and the positive impact this can have on the quality of their parenting.

In terms of barriers to involvement, the study found that 23% of fathers were never present during family nurse visits. The reasons for this were complex, including the timings of visits and levels of maternal vulnerability. Other structural issues highlighted by the study were the way that a mother is the 'client', leading to ambiguity by family nurses about how fathers were to be regarded. Whilst many nurses were skilled at involving fathers in the care of their babies, they also found that family nurses were sometimes challenged in how to respond to both mothers and fathers simultaneously, leading to a minority of cases where family nurses were thought not to be proactive enough and to hold negative views of a father. This study, sitting within the wider literature on the experiences of young fathers, helped to prepare me for the fieldwork, including ensuring that their voices were included in the data.

Critical policy research

The previous chapter set out the current policy framework concerning teenage parents. Here I present the literature critical of this framework. This sets the scene for the later discussion chapter, in which I consider how the views of FNP clients and family nurses contribute to this critique. A theme running through this literature is the ethical complexity involved in defining and intervening with teenage parenthood as a

‘problem’ (Duncan *et al.*, 2010; Kamp and McSharry, 2018). The TPS and its related interventions are critiqued for example, for treating young parents as devalued economic commodities (Cook and Cameron, 2015). Critics draw attention to how working class women are expected to comply with middle-class values (e.g. delaying childbearing in favour of first establishing a career pathway), even though they might not share the same culture or indeed have access to a ‘middle class’ route to adulthood, due to limited education and job prospects (Coleman and Cater, 2006; Dermott and Pomati, 2016; Alldred and David, 2010). This argument echoes critiques of policy and practice which is said to focus on mothers from poorer backgrounds, asking them to comply with particular parenting practices without addressing the effects of poverty on their lives (Featherstone *et al.*, 2014; 2018; Dermott and Pomati, 2016). Although there is a strong body of research, established practice knowledge and a legislative framework to support the idea that parental care is crucial for children’s well-being and development (Smith, 2010), the justification of professional intervention remains controversial, giving rise to questions about whether it is meaningful or desirable to define ‘good parenting’ (Boddy, Smith and Statham, 2011). Nevertheless, parenting has become a public health issue (O’Connor and Scott, 2007) within which notions of ‘good’ (and by implication ‘bad’) parenting are heavily drawn on within this social policy arena (Gillies, 2011).

Prevalent within this discourse is the received idea that having a baby at a younger age than the general population is inherently problematic and in need of eradication, due to its supposed links with sub-optimal parenting. This is contested by qualitative researchers (e.g. Alldred and David, 2010) who suggest that this way of thinking over-generalises and simplifies the connections between young parents and deprivation (Duncan *et al.*, 2010). Whilst there is no doubt that young parenthood is associated with social disadvantage (Hawkes, 2010), there is considerable debate within the literature about whether young parenthood is the *cause of* or *resulting from* social disadvantage. Following a comprehensive systematic review addressing this question, Lisa Arai, (2009) concluded that the findings are mixed and inconclusive:

Where extensive controls....for selection factors into early motherhood have been used by analysts, outcomes for teenage motherhood do not seem to be entirely attributable to the age at which child bearing began. Authors do often report that, though early motherhood can be demonstrated to have deleterious effects, these are not as strong as previously believed. (p. 84)

Echoing this, Duncan *et al.* (2010) ask - via their provocative title - "What's the problem with teenage parents?" and conclude that once variations are controlled, it might be more accurate to say that both young motherhood and poor outcomes are caused by pre-pregnancy social disadvantage rather than the other way around, leading them to conclude that it is social and economic circumstances, rather than age, which should be thought of as predicting later adversity. These circumstances include material deprivation such as inadequate housing (Formby *et al.*, 2010), alongside the cultural oppression mediated through experience of stigma, as has already been highlighted. Likewise, Hawkes (2010) shows that despite entering motherhood with significantly more disadvantage in terms of early life circumstances - what Smith-Battle (2018) terms an "unlevel playing field...saturated with health and social disparities" (p. 94) - the children of teenage mothers do not perform significantly worse at cognitive and behavioural indices (apart from in relation to hyperactivity) than do the children of older mothers.

Also running through this literature are the reported positive effects of being a parent by young parents (Clemmens 2003; Smith-Battle, 2008). Qualitative research in particular homes in on how treating teenage parenthood as a straightforward public health issue in need of eradication is disrupted by the value placed upon it by those who experience it. Despite adversity and a sense of loss with regards to teenage life, teenage mothers report how having a child represents a positive "turning point" in their lives because it "anchors the self, fosters a sense of purpose and meaning, reweaves connections and provides a new sense of future" (Smith-Battle, 2000, cited in Duncan *et al.*, 2010, p. 316).

Collectively this literature disrupts dominant narratives about the supposed inherent deficiencies of teenage parents. I found it very influential in my analytic process, particularly in terms of resisting deterministic approaches to understanding the experiences of teenage parents. By doing this, I hope to contribute to research evidence which promotes diverse and nuanced understandings of teenage parents, in which the social and economic causes of teenage motherhood are explored, rather than any perceived individual deficits (SmithBattle, 2018).

Neurobiologically based early intervention policy

The literature discussed above sits within a broader critique of de-contextualised policy and practice, particularly concerning safeguarding and child welfare programmes. Featherstone *et al.* (2018) and Firmin (2017) are amongst those who question individualised approaches, criticising the way that they tend to locate parents – usually mothers – as responsible for the behaviour of their children, without consideration for the complex interplay of structural inequality, cultural norms and wider systemic influences (Dermott and Pomati, 2016). De-contextualised policy is linked within this literature to an over reliance on Randomised Control Trials as the ‘gold standard’ of scientific proof of the efficacy of an intervention (Perkins, 2015, cited in Featherstone *et al.*, 2018, p 47). Rather than drawing on a broad base of research knowledge from the social sciences and practice, early years policy in particular, has, these scholars argue, become part of the “biological turn” (Featherston *et al.*, 2018 p. 58), wherein neuroscience is deployed to both rationalise and shape policy and intervention (Koffman, 2015). Within this discourse, ideas of “the infant brain damaged by neglect is a key contemporary leitmotif” (Featherstone *et al.*, 2018, p. 47), and becomes the site of attention.

Whilst most of the critical policy publications in this area draw on secondary sources, an exception is Edwards *et al.*’s research (2015). It is worth singling out because of its inclusion of eight FNP professional participants, along with

politicians and leaders from the early intervention sector. The motivation for the research was to examine the:

‘Neuromolecular gaze’...a hybrid style of thought, approach, language and perception that reduces understanding of complex phenomena to a molecular understanding gathered around the brain, and which means that intervention in the brain can shape behaviour. (p. 5)

The study found a naïve rendering of this problematic discourse in which a “cultural deficit model” (p. 11) was used to justify a focus on change. This involved positioning mothers as having the necessary means to control their circumstances and those of their child/ren, when in reality they may well have little control of either due to social inequality and disadvantage. They identified benignly intended assumptions by practitioners and policymakers that “the poor are underdeveloped, that there is something missing in their brains, that they do not experience normal emotions, and most powerfully that they do not love their children like ‘we’ do” (p. 14). To support their critique, the authors draw on alternative neuroscientific scholarship which questions the notion that the way that mothers interact with their children before they are three years old has a ‘hard wiring’ effect on their brains, determining their emotional and social development, arguing that the evidence on this remains inconclusive.

The authors suggest that the uncritical adoption of these ideas may be down to the ubiquitous pressure to justify funding in an age of austerity when every penny must be seen to be doing something productive and evidence-based – the more ‘scientific’, the better. Highlighting the complexity in this area of policy and practice, they recognise that neurobiological research can be deployed in either emancipatory or pathologising ways¹. This critical analysis helped me to be alert to the ‘biological turn’ in my data, and to how the pressure to justify financial investment in the service played out. Building on Edwards *et al.* (2015)’s work,

¹ For example, the ACE (Adverse Child Experiences) agenda - which highlights an association between early experiences such as trauma and later health and social outcomes - can be narrated hopefully through a recognition of the ameliorating effects of adult relationships. However, it can also pathologise through blaming, reinforcing moralistic arguments about the deficiencies of the poor.

which could be thought of as ‘standing at the side-lines’ and issuing a warning to the sector about its ethical contradictions, my study has allowed me to ‘get onto the playing field’, as it were, and grapple with the issues from within. There are clearly risks involved with my more enmeshed positioning - as I discuss in my methodology. However, with good structures and reflective measures, it allows the ideas discussed here to be considered in the light of close observation – rather than only narrated - FNP practice. The fact that my study also involves investment by, and access to, FNP’s leadership further extends the potential for integrating this learning into future practice developments by opening up greater opportunities for dialogue with those implicated within this critique. These issues are all the more pertinent since the NU became part of PHE’s First 1000 Days initiative - a government policy which attracts similar critiques to those rehearsed above (Moore, 2018). I hope that this further extends the potential impact of the dialogue and thinking that this research facilitates.

Neoliberalism in policy

Impacting all of the issues discussed thus far is New Public Management (NPM), which, since the late 1990s has become a “dominant transnational force intersecting with other local and traditions and trends” (Cooper, 2018, p. 62). Critiques of deterministic, formulaic approaches to early intervention, discussed above, link them with a political agenda in which individualistic ideas about choice and responsibility have taken hold (Nozick, 1974). This has seen the widely criticised marketisation of health and welfare services (Borland, 1995), in which a business model has been applied to services, with the aim of reducing costs (Learmonth, 1997). The result has been a split between the allocation of resources and clinical/practice concerns, leading to a conflict in purpose and task due to the absence of an authority structure able to integrate both sides (Owens, 2015). Other consequences of NPM are a focus on standardised, target-driven processes, through increased top-down management as a way of improving performance (Featherstone *et al.*, 2018); surveillance, inspection and obsession with risk management over welfare needs (Beddoe, 2010); the quantification of outcomes over qualitative professional narratives leading to tasked focused practice and supervision (Ruch, 2012); decreased levels of confidence in the containing structures of

institutions such as the NHS; and a corresponding increased uncertainty and anxiety about survival, accountability and complex 'governance' structures (Cooper, 2018).

This context has major implications for the FNP model, which operates within an increasingly competitive environment. Holding in mind the interests of commissioners, whilst not being overly dominated by them, is just one of the challenges. Whilst most FNP sites are provided by NHS Trusts, some are not (Dodds, 2009). This is the 'brave new world' where private companies like Virgin, or social enterprises, hold contracts for FNP delivery. If it is difficult within the current system to ensure supportive, containing structures at a local site level, this is surely made all the more challenging with a provider landscape that is further fractured. Indeed, reflective practice and supervision are countercultural under NPM, due to the shifting emphasis "from reflection, personal development and support, to a model dominated by targets, case discussion and action planning" (Hunter, 2010). Within the FNP model, supervisors are particularly exposed in this respect, due to their location at the border between managerialist agendas and expectations that they will alleviate emotions generated by practice (Ruch, 2012; Andrews and Oxley, 2015/2016).

As discussed, following the financial crisis of 2008, the government increased its efforts to reduce the welfare state, under the auspices of austerity (Vize, 2011). The resultant cuts to services – which includes for example, the closure of an estimated one thousand Sure Start Centres since 2010 (Butler, 2018) has had a double effect on welfare and health services: with austerity disproportionately affecting those most vulnerable in society, their social needs have increased, placing greater demands on the few services which remain. This is particularly significant for a programme like the FNP which has such a far-reaching, ambitious vision to bring about transformation in the lives of its clients, if what can be achieved under these reduced such circumstances is in fact, modest (Cooper and Lousada, 2005).

Just as critics argue for a contextualised view of the lives of teenage parents, the value of this literature was to orientate me towards a contextualised view of FNP as an organisation. It allowed me to appreciate how factors at the meso and macro level

might affect FNP achieving its aims, through the enlivening of defences in response to managerialist agendas, rather than, say the clinical task (Cooper and Lees, 2015). Indeed, even as FNP seeks to position itself as counter-cultural to deficit-led risk approaches (Ferguson and Gates, 2015) and despite its focus on relational person centred methods, it has attracted criticism for being complicit with NPM. Dodds, (2009), for example, claims that FNP's perceived procedural approach is "a logical extension of the increasingly pervasive notion that the 'socially excluded' are at risk to themselves (and possibly to others)" (p. 501). The concept of 'risk' – as opposed to 'need' - has been used instrumentally under NPM to reduce universal provision, in favour of targeted intervention within a deficit-framework focused on those who are thought to be 'at risk' (Boddy *et al.*, 2011). This allowed societal issues to be recast as private, individual responsibilities (Kemshall, 2002, cited in Dodds, 2009, p. 501). By analysing the SEU's publications, Dodds (*ibid.*) suggests that FNP claimed to be able to reduce the risk "of everything from kidney problems to promiscuity, and explicitly proposed that the new scheme should be focused on those 'at risk'" (p. 508). She concludes therefore, that whilst FNP might improve clients' access to resources, its model fits within an NPM agenda as exemplified by the SEU's interest in achieving social change through changing individuals rather than by reforming structures.

Collectively this literature addressing NPM, and FNP's relationship with it, provided a helpful introduction to the complexity surrounding the FNP system. A description of the structure is enough to make this point: headed up by a National Unit with responsibility for fidelity to a licence validated by an American University, FNP sits within a specific national governmental policy framework, is commissioned by up to 80 different local authorities, each with their own priorities. It is delivered by a diverse collection of health providers and mediated by hundreds of individual nursing practitioners, with varying specialisms, in relationship with thousands of clients, in their own homes. As Hoggett (2006) argues in his aptly titled paper: 'Conflict, ambivalence and the contested purpose of public organisations', ethical tensions and diverse perspectives within such a context are surely inevitable.

To summarise the critical policy literature, this work highlights how mothers and fathers who are young are not a homogenous group. It suggests that straightforward associations between teenage parenthood and disadvantage should be replaced by nuanced, contextualised understandings which consider socio-cultural factors and the perspectives of young parents. Although research into the lives of young mothers and fathers reveals that they experience considerable hostility, current social policy fails to address this significant issue, and therefore may, albeit inadvertently, be contributing to it. It is for this reason that my discussion chapter explores how the experiences of young parents and nurses speak to the issues raised in this literature.

Related models and intervention approaches

Having explored the literature relating to the experiences of young parents and homed in on the critical debates about policy in this area, I will now review the literature relating to the organisational practice methods adopted by FNP. Here I set out comparator organisational models and settings which are relevant to FNP's approach, as well as an overview of the research focussing on practice based relational methods. This will further contextualise FNP in relation to its contemporary or historic partners in the fields of community nursing, family support, child welfare practice, early years and early intervention, whilst also contextualising this study's particular focus on the relational aspects of the FNP model.

Comparator organisations

As I discussed in the introduction to this chapter, organisations and methods of practice which relate to the FNP model extend in several directions. These include community-based nursing models; early intervention family support practices and organisations with a similar 'target' population which cut across all three, often with a psycho-educational and relationship orientated approach. This section provides a brief contextual overview of these partners, and how they relate to one another, to support later discussions about the implications of this research to the wider sector.

Health roles – Community Psychiatric Nurses and Health Visitors

As the name denotes, the Family Nurse Partnership is located within the discipline of nursing. Family nursing shares common features with those areas of community nursing which typically involve home-visiting, including community mental health, health visiting, midwifery. These community based specialisms grew in prominence and expertise across Europe, the USA and Australia over the latter part of the Twentieth Century, mediated by a policy agenda and legal framework increasingly directed towards cost effective, individuated, preventative and early responses to health and social issues (Means *et al.*, 2008). From a mental health perspective, the years since the end of the Second World War saw investment in community-based psychiatric treatment (Chalmers, 1992) and a decrease in hospital/institutional care. In the late 1970s, the community psychiatric nurse role was established (Sheppard, 1991), filling the gap created when the social work profession moved from generalist to specialist disciplines (Short, 1985).

Combining domiciliary with out-patient care, community mental health nurses, as they are now known – draw on medical, social and psychological methods (Sheppard, 1991). Similarly to family nurses, they deploy therapeutic - usually cognitive behaviourist - and relationship-based methods, and engage with a patient's wider social network (Macleod *et al.*, 2011). Despite cross overs in terms of clinical practice between the two roles, there are however, structural and implementational differences between them, including the fact that mental health nurses are fully integrated into multi-disciplinary teams, whilst family nurses are not, for reasons which are explored further below.

Another key disciplinary comparator for family nursing is health visiting, known internationally under a variety of titles including community health, public health and district nursing (Philibin *et al.*, 2010). There is also a hybrid role encompassing information giving, advice and support, provided through negotiated inter-personal contact and delivered in community settings, including the home (Chalmers, 1992). Taking over maternal and infant care from midwifery in the first few weeks after birth, health visitors in the UK oversee the growth and development of children, undertaking

developmental screening as part of the Healthy Child Programme (DoH, 2009). There are obvious crossovers with family nursing here, indeed this is recognised by the fact that clients enrolled with FNP do not also receive a service from a health visitor for the duration of the programme.

In relation to these affiliated roles within health therefore, family nursing occupies a complex intra-disciplinary position, which can be analysed in terms of remit, scope and intention. Firstly, at a straightforward level, the *remit* of health visitors and family nurses is young children and their parents, whilst mental health care for adults with mental health difficulties. The *scope* of family nurses and mental health workers is defined around a narrow inclusion/exclusion, with an expectation of regular contact over a relatively long period. In contrast, health visitors have a universal, primary care reach, comprising all infant/parents within a geographical area, most of whom are provided with a small number of sporadic visits (Institute of Health Visiting, 2020). Additionally, FNP is not triggered by ill health but rather in anticipation of social problems developing, should the intervention not take place. This links to the *intention* of the roles, which in the case of family nursing and health visiting is prevention. This contrasts with mental health nursing which is primarily a response to particular psychiatric conditions.

Alongside its preventative agenda, however, health visiting also has a therapeutic intention (Philibin *et al.*, 2010). Research shows that this dual focus can lead to tensions (Edgecombe, 2005), role confusion and conflict (McKenna *et al.*, 2003). Similarly, family nursing, deploys 'selective prevention' (Cowley *et al.* 2012) alongside a preventive and therapeutic agenda, meaning that it is likely to experience similar complexities as those experienced by health visiting. This is all the more so as FNP prioritises social outcomes - namely the prevention of maltreatment of children within the teenage parents sub-population (Barnes *et al.* 2017), meaning that it has comparators beyond health – as I will explore next.

Wider health, social care and voluntary sectors

In the early years, local Children's Centres are the state's provision for child welfare health and support needs (Great Britain. House of Commons Education Committee, 2013) and family nurses interact regularly with them, supporting clients to access their services. Although increasingly under threat of budget cuts, they offer young families a range of universal and targeted services, including health and family support. The latter is a tailored version of the family support offer provided by many local authority children's social care 'early help' departments. Much expanded under New Labour's neoliberal state reforms (Churchill and Sen, 2013), such provision is characterised by needs assessed, targeted, outcome orientated, time-limited intervention, following a case-work approach. The focus is on reducing parenting and child behavioural difficulties and strengthening "family function" (Devaney *et al.*, 2013, p.13) through advice giving, intervention (i.e. budgeting, behaviour management) and increasing access to services. Whilst historically this work would have been undertaken by qualified social workers, this is no longer the case, with family support workers coming from a range of backgrounds, including youth work.

Methodologically speaking, state provided family support – be in children's centres or local authority children's services departments - bears similarities to the work of family nurses, including the voluntary nature of the professional-service user relationship. Occupying the same policy environment, all the most so since the advent of joint commissioning arrangements discussed earlier, they focus on the identification of risks and vulnerabilities, and the maximisation of personal and social 'resilience' (Churchill and Sen, 2016). There also is a common preoccupation with targeting resources towards the most vulnerable clients, intensified in recent years due to political and economic conditions (Churchill, 2013). The policy of austerity, adopted by the Coalition Government formed in 2010, has led to a reduction in funding for preventative children's services (Ridge, 2013). One of the results has been increased anxiety around identifying and reaching those believed to most benefit/be most deserving of, the few remaining services. Although this might sound logical and fair, critical research highlights the ethically hazardous nature of this approach, in which stereotyping and further disempowerment of already disempowered people can ensue (Duvnjak and

Fraser, 2013). This literature, therefore, helpfully highlights how FNP exists within the social policy and family practice arena, foregrounding possible sites of tension within this study.

Alongside state provided family support are voluntary sector providers of family services. These were much expanded by the New Labour Government, who commissioned out services, via a competitive tendering process on an unprecedented scale. The growth in Third sector delivery of family support services (Davies, 2011) complicated the hitherto independent nature of this sector (Cunningham, 2008). It also led to its increasing professionalisation: whilst some charities retained volunteers for service delivery, most now employ practitioners – qualified and unqualified social workers, youth workers and therapists - to deliver their contractual arrangements, as aligned to local multi-agency strategies. Methods deployed draw on those already discussed, including task-orientated and relationships based voluntary support.

National voluntary sector providers operate a similar organisational structure to FNP, with a centralised hub responsible for national lobbying, policy direction and training, and local affiliated groups responsible for direct work with service users. Examples include the Children's Society, Action for Children (formerly NCH) and Barnardo's, which have their roots in the Christian church (Eisenstadt, 1998), whilst those with secular beginnings include Family Action (formerly Family Welfare Association (FWA)) and the defunct Kidz Company. These organisations operate local and national streams, whilst inter-related, never-the-less often exist within separate funding and governance arrangements. The complex accountability field (Lewis, 2005) that these arrangements create, make the experiences of these organisations particularly relevant for understanding the operationalisation of FNP.

Contemporary statutory family case-work practice, as well as community based nursing, can be traced back to the historic activities of these charitable organisations. For example, the Family Service Units (now merged with the FWA) which grew out of the Second World War's pacifist movement; and Home-Start, a provider of home-visiting parenting support from the 1970s (Guterman, 2001), were both early

champions of the notion that children's needs are best met by their own parents. Long before it was adopted into government policy, they promoted 'think family'² i.e. addressing the needs of children as interrelated with those of their parents. This idea is also underpinned by the 'no order' principle enshrined in the Children Act 1998 (Great Britain) which states that children and families should be kept together whenever possible. It can be argued therefore, that certain principles and practices at the heart of the FNP model, such as addressing a parent and child's needs together, coalesces with the direction of wider contemporary family welfare approaches. Also, in terms of organisational structure and governance, FNP may have more in common with a large independent family support charity, than with its clinical partners in health.

Therefore, although FNP originated in the USA and is a nursing oriented programme, its adoption in the UK was no doubt facilitated by its easy assimilation within the local family support landscape. Its alignment with family orientated practice; its focus on targeting and prevention; and its ability to hold its own in a competitive, evidence focussed commissioning environment, provides FNP with a range of 'relatives' outwith the health sector.

Early intervention globally and nationally

Overlaying these comparators from health or social care is FNP's alignment within a growing international movement advocating preventative home-visiting programmes targeting child abuse. One of the first of its kind was the Hawaii Healthy Start Program of the 1970s (Guterman, 2001), which led to similar initiatives such as 'Healthy Families America' (Krystik, et al., 2008). With several cross-overs features with FNP, Healthy Families America provides family support with an emphasis on early nurturing relationships within a strengths-based approach (Mutscheller, 2019), laying claims to a

² The 'Think Family' approach (Department for schools, children and families, 2009) was introduced by the Government's Social Exclusion Task Force in the late 2010s as means of responding to 'at risk' families. Linked to initiatives like the Troubled Families agenda, it promoted co-ordinated practice which addresses inter-related issues within a family system, rather than tackling issues in isolation. It advocated the effectiveness of addressing the needs of parents as a means of improving outcomes for children.

substantial scientific evidence base. The approach has looser inclusion criteria to FNP however, allowing, for example, a negotiated, needs-led ending, in contrast to FNP where, historically at least, the service ends on the child's second birthday. This suggests that such programmes tend to be underpinned by either a social or a medical framework for assessing needs and eligibility for services, even when they ostensibly integrate methods from both arenas.

Informed by Adverse Childhood Experiences (ACE) scholarship (i.e. Felitti *et al.*, 1998), research into transgenerational cycles (i.e. Perry, 1996); and the connections between neurobiology and social problems (i.e. Shonkoff and Phillips, 2000), these programmes draw on a common 'theory of change' around the idea of early intervention. By integrating attachment and ecological concepts with neurobiological understandings of early childhood development, they are designed to improve the availability of cognitive stimulation and care for children living in economically and relationally disadvantaged families. Putting to one side the previously rehearsed critiques of the neuroscientific 'turn', (i.e. Featherstone *et al.*, 2018), I draw attention here to how FNP is part of an international community of projects and programmes hoping to prevent the maltreatment of children across current and future populations by focussing in on the micro-level at the earliest possible point in the lifecycle, i.e. the brain development of a foetus.

Within the UK, this activity is championed by organisations such as the Early Intervention Foundation (EIF), and initiatives like PHE's First 1000 days. The EIF for example, publishes a guide for commissioners, evaluating and assessing 75 programmes available in the UK which address parenting interaction for "children with signals of risk" (Asmussen *et al.*, 2016, p.10). Understanding this helps to further situate FNP within its national and international context, where governmental agenda exerts influence over organisational direction. At the same time the immense popularity of early intervention ideas within the wider child ware sector, along with the imperative to prioritise scientifically evidenced programmes, highlight the risk to organisations such as FNP of oversimplifying narratives of the 'problem' and the 'solution' (Moore, 2018).

Collectively, the comparator literature points to how the FNP model is both linked to, and departs from, its sector partners in complex and stratified ways. It suggests that its outworking in practice may be subject to multiple and conflicting ideas about who is, what it is for and why. Having considered the literature relating to FNP's sector partners, the next section focusses on empirical scholarship concerned with relationality and relationship-based approaches in order add to the contextualisation of the methods used by FNP.

Relationality or relationship-based approaches

Studies which consider relationality and relationship-based approaches within practice settings, particularly those that draw on empirical qualitative methods, are rare. Those which exist conceptualise relationality as connectedness to others, including an intrinsic notion of care and well-being (Ritchie, 2013). Adding to this, Waterhouse and McGhee (2015) explore how clients narrate themselves to, and are “apprehended” (p. 249) by, professionals - following Butler's (2005, cited in Waterhouse and McGhee, 2015, p. 1959) philosophical development of the idea of ‘recognition’ concerning maternal agency. Similarly, to Thomson *et al.* (2011), they draw attention to how teenage mothers feel compelled to present themselves according to a particular form of defended morality. This highlights the intersectional influences (e.g. class, race and culture more broadly) on what can often be high-stake relationships, in which there are complex power relations due to the potential for judgement.

Masciantonio *et al.*, 2017 explore this through in their study on the use of attachment theory for assessing mother-baby relationships. Rather than acknowledging its Anglo-American middle-class roots and culturally specific idea of the “exclusive biological mother” (Barlow and Chapin, 2016, p. 326 cited in Masciantonio *et al.*, 2016 p. 4), they found that attachment theory was presented as a universal phenomenon and used to justify judgements about families to whom it may not be culturally relevant. Within the context of the helping relationships, this created dynamics of power which were stacked against clients and in favour of professional expertise. Expanding my awareness of the subtle power relations within professional-service user relationships

as I approached my fieldwork, this literature helped me to understand how equal, non-coercive relationships can be inadvertently undermined if mothers feel compelled to give account *for* rather than *of* their mothering (Waterhouse and McGhee, 2015). Any naive notions of a 'good relationship' existing apart from the influence of a social and organisational context gave way during this process to an appreciation of their complex interdependence.

Highlighting how relationships are almost always seen in relation to other relationships, in de Boer and Coady (2007)'s work, when welfare-involved clients described the qualities of helpful relationships, they tended to also discuss workers they found less helpful. The features appreciated by participants were those elements which might be considered 'capacities' rather than 'skills', such as emotional depth and closeness, being 'down to earth', responding supportively rather judgmentally and following through with promises. Linking with Waterhouse and McGee (2015) discussed above (in terms of relationality and agency) the attributes most valued were a "judicious use of power; and (2) humanistic attitude" which included "seeing and relating to the client as an ordinary person with understandable problems" (p. 35). To work in this way however, the study revealingly describes how workers had to "stretch traditional professional ways-of-being" (p. 35) and were semi-apologetic and anxious about the levels of care and interest they showed in clients, rather than, for example, feeling supported by their organisational and professional context to do so. Although there is widespread evidence to show that what matters is the quality of a helping relationship, rather than the specific model deployed (O'Leary *et al.*, 2013), there remains a lack of certainty about whether it is possible or legitimate to maintain 'humane' relationships within a risk focused organisational climate. This often leaves practitioners confused about boundaries, resulting in their defensive rather than inclusive application (O'Leary *et al.*, 2013).

This scholarship gives rise to questions about what kind of management and organisational context would support humane professional-client relationships. With FNP's interest in intentionally building relationality into the implementation and delivery of its work across system levels (Rowe and O'Byrne, 2014), it is particularly

pertinent for this study. Whilst there is little empirical research in this area, Moore, from a neurobiological and child development perspective (2007) conceptualises how parallel processes are maintained through relationships within early childhood intervention services. He argues that relationships between parents and children; professionals and parents; managers and staff; etc. parallel each other within the system and have a significant impact on their collective development and well-being. To work intentionally with parallel processes involves paying attention to *how* services are delivered at every level. Moore (*ibid.*) claims that there is emerging evidence that even the nature of the relationship between governments and service networks can have a 'trickle down' significance at the micro level. This links to Ruch's (2012) work, which argues that containing, reflective, management support makes polarised and dehumanised practice less likely – as discussed further below in relation to the psycho-social literature.

By researching the nature of the relationship between family nurses and clients, this study expands the scholarship on client-professional relationships - which largely comes from social work - with a contribution from a voluntary inter-disciplinary programme within a health context. Emulating this literature, I aim to follow their approach in resisting assumptions and simplistic ideas about how relationships affect one another within practice environments, and to be mindful of over reliance on formulaic approaches which might:

Neglect the complexity of the intervention, and of parenting itself – as a dynamic, multi-dimensional and relational process that happens within a family system, and not merely a set of skills and behaviours that can be universally applied (Boddy *et al.*, p. 192)

The 'real-life' awareness advocated here is taken up in my later discussion, which, similarly to this literature, moves between policy and practice knowledge to build a rich understanding of how the FNP model is operationalised.

To complete this review I will next present the relevant literature related to my psychoanalytic conceptualisation of relationships and how this has influenced my positioning, drawing on both clinical and organisational research.

Psychoanalytic and psycho-social positioning

At the start of this chapter, I discussed the challenges with placing my research within an appropriate body of scholarship. Whilst the work discussed thus far has shaped my research decisions, ethical sensibilities and critical perspective, the literature which has helped to guide my conceptual and methodological approach has been psychoanalytic and psycho-social scholarship. The influence of this theory, or collections of theories, includes my position on the nature of human relationships. As I will explain below, this includes conceptualisations of relationships between individuals, at the practice/clinical level and conceptualisations of relationships within and between systems, as developed through the study of groups and organisations. In this section therefore, I will present the key literature that underpins my understanding in this area, the implications of which are expanded and elaborated upon throughout the rest of the thesis.

Relationality at the individual practice/clinical level

A tenet of psychoanalytic thinking is the concept of the dynamic unconscious (Woodward, 2015). This is believed to be an aspect of the human psyche where anxieties such 'raw' emotion and supposedly irrational fears, thought to be linked to early childhood experiences, reside (Freud, 1900 cited in Preston-Shoot and Agass, 1990). Within this paradigm, anxiety is understood as universally experienced, disliked and defended against (Maclean and Harrison, 2011). Defence mechanisms, which manifest in various ways, are not considered to be necessarily problematic, in fact, they are regarded as useful for everyday healthy functioning (Preston-Shoot and Agass, 1990). However, is it not possible to suppress those things which we are defended against completely, and, as such, our unconscious anxieties present in other ways.

Drawing on this paradigm, my position incorporates an assumption that human relations are characterised by both what is seen and known 'on the surface' and also by what is hidden and not always easily explainable - that which is 'below the surface'. Within this is the assumption that the inner world is fragmented and contradictory (Woodward, 2015) and symbolic (Britton, 1993). In other words, unconsciously held feelings and emotions can be seen in non-verbal communication: in the pauses, through body language, via gestures and slips of the tongue, dreams and in somatic manifestations.

Taking up this position influenced my research considerably, from choices about research methods to a more ubiquitous curiosity about the meaning of behaviour and practices, beyond that which might be immediately apparent. As the Methodology chapter explains, I was not seeking to interpret individual participants in the light of their childhood experiences. Rather, the belief that everyone is irrational and contradictory, including myself, was an important starting point for my positioning as a researcher. It allowed me to resist the pull towards 'tidy' outcomes, or to expect the data, heavily mediated as is by relationships, to be in any way 'straightforward' in its meaning. It was, for me an important ethical stance, which supported the taking up of collegiate relationships with participants, resisting any notion that I was safely ensconced behind a fantasy of a so-called 'objective' observational vantage point (McNamara, 2009).

Myriad schools of psychoanalytic thought have built on the foundational Freudian concept of the dynamic unconscious, to theorise aspects of the human psyche. My research draws on the developments emanating from the Tavistock Clinic, particularly the work of Melanie Klein and Wilfried Bion, to frame my psycho-social understanding of relationality. A Kleinian conceptualisation of object-relations focusses on how internal (psycho) and external (social) aspects of the world relate to one another and intertwine in complex ways (Woodward, 2015). Developed originally to understand the emotional development of very young infants, Klein (1946) observed the way that a baby's interactions with her or his mother is suggestive of a state of mind that shifts from 'part-object' (paranoid-schizoid) to 'whole-object' (depressive position)

functioning. A paranoid schizoid mentality derives from experiencing a mother as partly an object of love and nurture and partly an object of rejection and abandonment. Gradually, if all goes well with the infant's care, the external world, represented by the mother, becomes more integrated in the child's mind. In a process which is accompanied by the baby's guilt, grief and attempts at reparation for perceived previous damage inflicted upon her, the mother gradually becomes a 'whole' object, someone who is now experienced by the child as capable of both 'good' and 'bad' (Klein, 1946; 1952).

I draw on object-relations in several ways in this thesis. From a clinical perspective, for example, I consider the significance of the parent-infant dyad at the centre of the FNP model's developmental task, and the implications of this for the organisational task. More broadly, as I discuss below, I also draw on Kleinian ideas as applied beyond the clinic and individual emotional development, to think about how groups collectively operate in 'part' or 'whole' object ways, depending on both the constitution of the group and their environmental circumstances. The idea that individuals, groups or organisations can achieve 'depressive position' functioning (Klein, 1952) – that is, an integrated way of relating to others which resists splitting them into either 'good' or 'bad' – is a thread which runs through the discussion chapter, particularly linked to the idea of paradox.

Within a Kleinian understanding of psychic and social development, is the possibility for unconscious affect to transfer between people, in ways that they are not necessarily aware of. This transference of feelings takes place through the processes of projective identification and introjection (Hinshelwood, 1991). These terms refer to the way that an infant *introjects* or takes in, their mother as a good object, to achieve depressive position functioning (Klein, 1955). Meanwhile, projective identification describes a process of evacuating unwanted or difficult aspects of oneself and attributing them to another – 'external' object (*ibid.*). Sometimes, the one who has been projected onto can feel or respond in ways which align with the unconscious expectations of the projector, in a process called counter-transference (Klein, 1952). This is a key method utilised during Kleinian clinical psychoanalysis.

Drawing on these ideas, my understanding of relationships and relational practice is informed by the idea that individual and groups ‘pass on’ unwanted feelings to one another (Frosch, 2012). How these feelings manifest and are worked out in others is linked to the quality of the containment available to them – a process which enables processing and thinking to take place, and reduces the likelihood of feelings being ‘evacuated’ onto others because they feel intolerable (Finch and Schaub, 2015). This links to the theoretical idea developed by Bion to explain the process by which a mother ‘contains’ the feelings of her infant, facilitated by a process described as ‘reverie’ (Bion, 1962).

Building on Kleinian thought, Bion, developed the concept of containment to describe how a mother comforts her distressed child by enabling her or him to “internalise a container of feelings but also a mind that can hold thoughts” (Salzberger-Wittenberg et al., 1983, p. 60). Through the bearing of uncertainty, pain and fear, a mother (and I would contend, a father also) enables a child to manage strong feelings and develops their capacity for thinking. Applied clinically, the importance of this process is that through a relationship with a containing other, the analysand/service user/client has the potential to draw on their expanded thinking capacity to bring about desired changes (Larner, 2002). This conceptualises the way that anxieties can be experienced, thought about and learnt from, in the context of a containing relationship (Bion, 1962).

Links with FNP approaches

As with psychological defences, the idea of containment has entered mainstream thinking, particularly within the human services (Ruch, 2007). Therefore, whilst many of the psychoanalytic concepts discussed above do not feature overtly in FNP’s description of its theoretical underpinnings – as set out in the previous chapter - the idea of containment is referenced and utilised throughout the FNP model, particularly when it comes to supervision. Within FNP, the language of parallel-processes is used to describe how practices, feelings and processes can be mirrored at various levels of an inter-dependent organisational system (Ruch, 2007) – such that, for example, the containment provided by supervisors to FNP nurses can be ‘transferred’ to FNP clients,

and subsequently by clients to their babies. This systemic way of thinking coalesces to some extent with psychoanalytic ideas of transference, in the sense that there is an acceptance and expectation that feelings and ideas that manifest in one setting, can become present in another and that the primary means of this movement is human relationships.

As well as influencing my approach to understanding supervisory containment within the data, the concepts of transference and parallel-processes also underpinned my wider methodological decision to include personal responses to the fieldwork as data. These responses were, I believed, potentially revelatory of transferred affect, in the context of research relationships with participants in the field, which could help me to better understand what was 'going on' (Hollway and Jefferson, 2000). At the analytic level, I utilised these concepts to think about how the positioning and treatment of teenage parents within neoliberal social policy, might be transferred and paralleled within the FNP model; and how teenage parents are projected onto ideologically by society, based on historic conceptualisations (Kemp, 2014) of deviant women.

One of the three main theories underpinning the FNP programme is self-efficacy (Bandura, 1997), which promotes the role of self-belief for enabling the fulfilment of expectations and goals. My understanding of how this process is conceptualised within FNP is that self-efficacy in clients is encouraged through vicarious experiences, in which desired attitudes and behaviours are modelled through relationships i.e. a nurse 'teaches' a client to believe in herself by showing her that she believes in her, and in a less obvious way, that she also 'believes' in herself.

Modelling is also important for another FNP's key theoretical concepts, namely attachment theory (Bowlby, 1969). As with containment, the FNP model is designed to facilitate a family nurse developing a long-term relationship with a client which is models good attachment behaviour: it is consistent, empathetic, and supportive. This is intended to help a client 'learn', through the experience, to increase her emotional and cognitive capacity, replicating similar relational bonds with her baby. Here, there are key areas of departure between FNP's theoretical base and psychoanalytic

thinking/practice. For example, psychoanalysts do not overtly model ways of being for their clients to replicate and are usually less interested in bringing about particularly behaviours as are they are in states of mind and feelings 'in the room'. Whilst the FNP model is often referred to by its members and stakeholders as 'therapeutic', the methods that it draws on most explicitly align with behaviourist understandings of human psychology, such as motivational interviewing and cognitive behavioural therapy, rather than psychoanalytic or narrative methods.

However, as I have already noted, there are also significant points of alignment between the FNP model and a psycho-social position on relationality. For example, there is a shared belief that people can develop new internal emotional capacities through a relationship with a containing other, even if the detail of *how* this takes place might differ. At the practice level, FNP nurses, like psychoanalysts, try to resist the pull to set up client relationships characterised by 'rescuing'. Rather they have the arguably more ambitious goal of forming an emotionally honest relationship, in the hope that a client might gradually 'take in' and integrate aspects of the nurse into themselves. Crucially both psychoanalytic theories and the FNP model are predicated on the idea that the relationship between a client and a professional can, in itself, be a learning environment for psychological processes, aside from any overt educational activity that may take place. Finally, FNP – at the NU level at least - and psychoanalytic theory also share an acknowledgement that individual practice relationships and the wider organisational/social system are inter-dependent. FNP leadership acknowledge that there is a need for the integration of micro, meso and macro level activity for organisational containment to exist (Ruch, 2007).

Having set out the key psycho-social literature which underpins my conceptualisation of relationships, and explored how they coalesce with, and depart from, the conceptualisation of relationships within the FNP model, I next turn to review the literature concerning the psychoanalytic study of groups and organisations.

Relationality at the organisational and social level

Although empirical studies from this perspective are few, the scholarship does helpful conceptual work around how phenomenological relational experiences in groups can be theorised through the lens of conscious and unconscious activity (Hollway and Jefferson, 2000). Within this terrain, internal psychological processes can be thought about in relation to their collectively expressed group manifestations, in a way which offers new insights and liberation for those involved.

I was introduced to thinking in this way via Menzies-Lyth's (1959) seminal study into the high attrition rates of nurses at a London based teaching hospital. This work provided me with a way of considering FNP in terms of possible social defences against anxiety in response to their primary task - a concept which I explore in detail during my discussion - and the social organisation of affect and the unconscious (Hoggett, 2015). 'Defences' in Menzies-Lyth terms, were conceptualised in terms of organisational processes - she noticed, for example, how the hospital was set up to avoid nurses developing relationships with patients, thus avoiding the pain and loss associated with this. She noted that although this defence served its function on one level, it also led to nurses being dissatisfied because it cut them off from the relational work they came into nursing to do (Evans, 2014). Of particular relevance is Menzies-Lyth's conclusion that "the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety" (p. 78).

This relates to Bion's (*ibid.*) concept of containment, described above, whereby a primary carer enables a pre-verbal child to process their uncomfortable feelings through a process of 'reverie' in which the carer receives, digests and 'gives back' difficult feelings to her child, thereby making them more tolerable (Waddell, 1998). Applied to organisations, Menzies-Lyth showed that the way that the setting is organised (i.e. the managerial structures in place (Ruch, 2007)) can be compared to the way that a mother might contain the feelings of her child. Her approach, and that of others who followed her - such as Tutton and Langstaff (2015)'s study of nurses' use of emotional labour which enhanced patient recovery - has helped me to consider the relevance of the availability of containing structures within the FNP model. This is

particularly the case as parallel processes, discussed above, is widely used within FNP to justify the supervisory structure. Methodologically I also hoped to follow Menzies-Lyth's emphasis on the researcher/participant relationship, which she described as "sociotherapeutic" (p. 43), mediated through qualitative research methods.

As I explore further below, despite the ground-breaking nature of Menzies-Lyth's work (Armstrong and Rustin, 2015), it has not been widely applied with empirical research (Fotaki *et al.*, 2012). It has, however, been taken up and developed by psychoanalytic organisational consultants working within the Group Relations tradition. Key edited collections from this perspective - namely Obholzer and Robert's (1994) *The Unconscious at Work*; Hinshelwood and Skogstad's (2000) *Observing Organisations*; Kenny and Fotaki's (2014) *Psychosocial and Organization Studies: Affect at Work*; and Armstrong and Rustin's (2015) *Social Defences Against Anxiety* - are rare examples of edited collections which explore the theoretical value of integrating the emotional and unconscious dimension of life into the critical study of organisations, using psychoanalytically informed observation. Menzies-Lyth's (1959) approach to deploying psychoanalytic theory to research methods has also influenced the development of psycho-social studies more broadly.

A key collection which speaks to this is Clarke and Hoggett's *Researching Beneath the Surface* (2009), whose evocative title I use repeatedly in this thesis as shorthand for a multi-layered enquiry which seeks to go beyond discursive research approaches through the paying of close attention to unconscious features. This work develops the concepts of researcher reflexivity based on psychoanalytic principles, by advancing the concepts of the "defended researcher" and "defended subject" (p. 12). Building on the influence of clinical psychoanalytic literature described above this collection provided me with an epistemologically and ethically congruent non-hierarchical stance to emulate, which avoided any implied (and false) superiority over research subjects. Having a language for understanding the shared nature of the affective field, I was better equipped to position myself in relation to 'my' research subjects and to navigate the entanglement of emotions (Price and Cooper, 2012) that the research stirred up within me – as explored in the next chapter.

Collectively the psychoanalytic and psycho-social literature on organisational research was instrumental in developing my methodological choices and epistemological position. It was also useful for sharpening my understanding of concepts originating within individual clinical practice described above, latterly applied and adapted to research with groups and organisations. Taking, for example, the concept is 'transference' and its related 'counter-transference' as it is used within the research field. Transference, as I have set out, refers to object-relations processes between individuals (for example a therapist and client (Bion, 1962)) in which there is "the unconscious need to make the present relationship fit into the psycho-dynamic structure of a previous one" (Mattinson, 1975, p. 34) and countertransference is a reaction to the transference (Preston Shoot and Agass, 1990). Within the study of groups, the concept is developed to think about how the sociotherapeutic process referred to above, between a researcher and her field of study, replaces that of the therapist and patient, such that the researcher/consultant experiences unconsciously transferred feelings from participants (Hollway and Jefferson, 2001). Rather than being used to analyse the individuals involved however, this knowledge is deployed to uncover the transference of unconscious processes more broadly within a given social system. In the extract below, Armstrong and Rustin (2015) discuss how anxiety about learning is transferred within education systems, linking it to the previously discussed ideas of group defences and containment:

A significant anxiety for teachers must be that their students fail to learn; this may lead teachers to fear that they are failing too. This is linked to the larger anxiety inseparable from learning itself, which inherently involves the risk of “not knowing” and the vulnerability that comes from this. This may indeed be the central anxiety, intrinsic to learning, present in all educational environments. It is then one of the essential tasks of educators to contain the vulnerability of learners, so that they can tolerate not-knowing for long enough to be able to learn and change. When this anxiety becomes overwhelming, unconscious organizational defences are liable to emerge. This may include the scapegoating of failure, expressed through an excess of blame or exclusion; mechanistic prescription and regulation of how learning is to take place; and the displacement of complex learning by concerns about external recognition or disgrace. (p.14)

A psycho-socially aware researcher in this setting might, therefore, experience feelings of anxiety about their learning process. This could be a combination of their own psychological make-up and transferred feelings from the field. This sort of analysis is multi-layered and involves trying to build knowledge about individuals and group behaviour from several perspectives. As we see in the extract above, the source of affect within organisations is not fixed. One of the most important recent developments in this field which influenced my thinking is concerned with how contemporary organisations, operating within neoliberal contexts generate defences which are a response to wider service delivery environment (i.e. the commissioning agenda) as much as from the core activity (i.e. the direct work with teenage parents) (Hughes and Olney, 2012, cited in Lawlor, 2013).

Another key concept drawn from this literature, particularly instrumental in my late analytic stage, was the ‘depressive position’. As described, this Kleinian concept describes the stages of development of an infant in relation to her or his mother. As a brief reminder, from the clinical perspective, Klein (1935) observed how a baby begins life in a ‘paranoid-schizoid’ state of mind. This is when the external world is experienced as part objects (Halton, 2015) - either the withholding ‘bad breast’ (paranoid) or the feeding ‘good breast’ (schizoid). Within a containing environment, the child becomes aware that both the ‘good’ and ‘bad’ breast emanate from the same

source. This leads to feelings of guilt for harm caused by aggressive feelings, directed towards the mother (when she was perceived as the 'bad' object), whilst a realisation of dependency upon her also ignites a desire for reparation (Evans, 2015). A depressive position equates to the psychic capacity to tolerate an integrated and realistic image of the external world, rather than having to split it into elements which are either wholly good or wholly bad.

As with the other concepts discussed above, the depressive position has been usefully applied to the study of groups and organisations. In one of the few examples of empirically based psycho-social organisational research studies, Cooper and Lees (2015) consider how public policy in the child protection arena is a manifestation of persecutory anxieties enlivened by fear of allegations of failure. The dominance of this paranoid position ironically leads to a defensive professional obsession which precludes the "vulnerable or suffering other" (p. 245). This is clearly highly problematic for a human service organisation tasked with the care of those who are vulnerable, fracturing the possibility of achieving a depressive position.

Besides informing my conceptual and methodological approach, the literature in this area provided a strong rationale for the value of developing new ways for utilising psychoanalytic theory to inform social and public policy (Froggett, 2002; Taylor 2001). As a theoretical framework, it provides an "advanced and compelling conception of human activity" (Fotaki *et al.*, 2012, p. 1105) but remains underused due to the unusual training and skills needed for its successful deployment within the social sciences (Gould, 2004). I am fortunate to have indeed had an unusual training in psychoanalytically informed social work practice which, I believe, has given me the necessary capacity to observe the "third dimension" (Mosse, 1994, p. 6), within the rigours of empirical social research. As such, I hope to advance this scholarship by bringing together elements that are currently under-represented in psycho-social organisational research - namely interdisciplinarity and the incorporation of the perspectives of those who use services, alongside those who deliver them. My study sits within a niche, emerging, body of scholarship, which promises to yield innovative

integrative knowledge which reflects and speaks to the reality of multi-dimensional lived experiences.

Conclusion

This chapter has demonstrated that the research context for this study is multi-disciplinary and diverse. Whilst there may not be an abundance of material which closely mirrors the methodology or subject focus of this project, there is strong evidence that it fits within, and speaks to, several domains in a timely manner. Overall, the literature points to the fact that this is an ethically complex terrain, where the risk of 'othering' young parents is high. Indeed, this one of the reasons why my study design includes a multi-dimensional perspective to gather the views of those who design, deliver and use FNP services. Listening to diverse views offers the opportunity to deconstruct and question assumptions about the FNP model – the imperative for which recurs throughout the literature. The scholarship drawn on in this review links to and underpins my study, but also in key ways diverges from it. This provides a strong justification for the need for this work, which has the potential to add new knowledge to several important and under-researched areas including applied social policy in a neoliberal context, psycho-social understandings of organisational practice and the contemporary experiences of teenage parents.

Chapter 3: Methodology

“Beyond here there’s no map.
How you get there is where
you’ll arrive....”

Heading Out – Philip Booth

Introduction

This study is concerned with producing new understandings of the FNP model by connecting together diverse perspectives. It seeks to produce a complex type of knowledge that involves ‘digging down’ into embodied phenomenological experiences and ‘scaling up’ by considering these in the light of the contexts - organisational, cultural, social, historical and political - in which they take place. Following Heidegger’s (1927) philosophy that the material world and the thinking mind are intertwined (Smithbattle, 2008), my assumption is that human behaviour is inextricably linked to context (Minnis, 1985). I therefore, take a qualitative analytic position, drawing on inductive thematic and grounded approaches, striving for an open (but not empty) mind (Dewey, 1966). This involves a commitment to systemic and psycho-social frames of reference, in which individuals, families, teams and organisations are assumed to operate within local, national and global systems and where conscious and unconscious psychic processes are at play. This is held together with a belief that the meanings that participants themselves attach to behaviour are key to understanding “what is happening here?” (Charmaz, 2006), framed by pluralistic notions of ‘reality’, within a qualitative intellectual tradition accepting of the contested nature of the socially constructed world.

Complex knowledge building requires a multi-layered conceptual framework. To facilitate this, as this chapter explains, I draw on three meta-theories to provide my conceptual foundation. My study design, which follows, explains how my theoretical position required going ‘beneath the surface’ (Clarke and Hoggett, 2009) of the FNP model, through a ‘practice-near’ (Cooper, 2009) immersive study design, using a relationship-based, iterative approach (Ruch, 2016). The chapter concludes with an extended psycho-socially informed reflective account of the execution of the study

design and the learning that this afforded, paying careful attention to ethical concerns, the execution of the fieldwork, and the analytical process I followed.

Meta-theory

Given my interest in pursuing a qualitative approach, I align myself with a post-structuralist understanding of 'reality' as a relativistic social phenomenon, mediated through subjective experience and language (Houston, 2001). As Gulson and Parkes (2010) argue, drawing on the work of Ball (1995, p. 79), I recognise the way in which discourse frames meaning and how this is contingent on context for interpretation/s. I do not, therefore, make reductionist claims about 'reality' through the findings of the study. Rather, I will narrate a constructed view, mediated through an understanding of multiple and multi-layered intersectionalities (Anderson and Collins, 2016), and which, following Foucauldian thought, is recognised as bound and differentiated by culture, language, discourse and power (Belsey, 2003). A post-structuralist position supports paying attention to marginal and diverse voices, which also align with social work's preoccupation with "*power, difference and meaning [sic]*" (McNamara, 2009, p. 192). In particular, this study draws on constructionist ideas of gender from a feminist perspective to consider the 'taken for granted' roles in domestic and professional settings. I reject the Cartesian view of reasoned neutrality acknowledging that "we are constituted, for better or worse, by our bodies and the meanings available in our family and cultural practices" (SmithBattle, 2008, p. 522) which for me include being a University educated, white, middle-aged, Welsh woman, from a working-class family – all of which contribute to the political, cultural and philosophical positions I take up here. I am also a social worker, engaged in an interdisciplinary study which is situated within a health and social care setting, in which an emancipatory position on human agency and embodied experience are central (Houston, 2001). Therefore, along with social constructionist theory, I also require an epistemological framework in which practice knowledge can be applied in the pursuit of social change: this can be found in critical realism.

Critical realism is a meta-theory which assumes that there is a 'real' world which "exists independently of our knowledge of it" (Sayer, 1992, p. 5), whilst, crucially, acknowledging that this can never actually be proven or fully known. The epistemological concern for critical realism, following Bhaskar (1978), is on explanation and cause, rather than proof. This involves attending to "deep generative process and structures" (Easton, 2009, p. 122) to uncover the 'mechanisms' which generate events – events which are 'real' in the sense that they cause events to occur (Houston, 2001). This is not a return to hard determinism; rather it is a perspective which assimilates social constructionist ideas into a somewhat more pragmatic philosophy, in which it is possible to postulate 'tendencies' (Houston, 2001) to explain and make sense of the data – albeit tentatively and partially. Research centres on identifying, analysing, understanding and explaining such tendencies and the development of transitive understandings – transitive because ever-present is an acknowledgement that knowledge is fallible and theory-laden (Sayer, 1992).

Additionally, it is ethically important for the ontological and epistemological basis of this study to be congruent with how 'reality' is utilised within FNP practice. Quoting Mouzelis (1991), Houston (2001, p. 849) argues that the exclusive focus on text and language as the site of meaning within post-structuralism has de-centred the human subject from social analysis. In contrast, critical realism offers a research project such as this – which has at its heart the empowerment of human subjects within complex social networks – "a theory of the human agency whilst at the same time taking account of the impact of social structure" (Houston, 2001, p. 6). This study, therefore, works on the pragmatic, contingent and "respectful conviction that there are underlying psychic and material realities" (Urwin and Sternberg, p. 8, 2012; Price and Cooper, 2012). Bhaskar (1978) showed the value of a critical realist approach to uncover both oppressive and empowering psychological and structural mechanisms (Lewin, cited in Houston, 2001, p. 13). As a study which is likewise concerned with structural opportunities and obstacles within an organisational system, this approach is particularly facilitative for foregrounding the emancipation of the human and welfare subject.

In order to consider psychological and structural mechanisms, however, critical realism alone is insufficient. To truly 'dig down' so as to be able to scale up', as the title of this study promises, to uncover the 'deep structures' of interest to critical realism, a third meta-theory is required, namely psycho-social theory. Hoggett (2008) writes that socially constructed ideas of contemporary identity theory fail to address "a concept of a loving and hating subject with an internal world that comprises real and imagined relations – the inner world of the subject is missing" (p. 70). Whilst critical realism, following Bhaskar (1978) foregrounds human and welfare subjects, psycho-social theory expands this to consider how such subjects are both knowing and defended – "each is knowing but also unknowing" (Froggett, quoted in Hoggett, 2008, p. 77). Bringing the two theoretical frameworks together allows for a conceptualisation of the interplay between 'internal' and 'external' worlds, and a way of talking about those things which may be as yet unknown to conscious awareness (Clark and Hoggett, 2009), assuming a 'dynamic unconscious' which "although perhaps beyond scientific proof, is not beyond evidence or systematic methodological investigation" (Hollway, 2015, p. 74).

This study is concerned with both 'digging down' and 'scaling up' – that is, the isomorphic links between micro, meso and macro system levels. The psycho-social notion of organisational and social defences against anxiety, set out in the literature review, enables a way of doing this which avoids the potential for pathologising individuals. It does this by linking together the psychological and socio-cultural elements at work within social systems to consider affect writ-large. This is particularly significant for FNP because of the strong feelings enlivened by work with young babies (Ruch, 2010) at the clinical level; and, at the managerial level, the effects of the contemporary socio-political context (Cooper and Lees, 2015). As my Literature Review described, I will, therefore, draw on key psychoanalytic context applied to social context. These include transference and countertransference, containment, defences against anxiety and the depressive position – a brief description of which is contained in the glossary section. I will use these ideas to consider the interplay between unconscious and conscious dynamics at diverse system levels, hoping to generate rich descriptions of FNPs complex social systems. Additionally, the generative potential

within both critical realism and psycho-social theory for social change are facilitative for this study – the former in its focus on emancipation (Bhaskar, 1978), and the latter in the theorisation of emotional containment leading to self-awareness, thinking and growth (Long, 2015; Papadopoulos, 2015). Drawing on this, the study offers a ‘formulation’ of the FNP model within the UK, which I hope will open up new possibilities and ways of thinking for its leadership.

Validity, reliability and generalisability

The objective of this study is to achieve interpretative rather than statistical validity (Hinshelwood, 2010) – asking ‘how’ and ‘why’ questions which seek explanations (Wellington, 2010) and build new understandings. As I explain further below, this required the use of small samples acting as ‘case studies’ of the wider whole. In response to questions about the applicability of the findings in other situations, this study takes a *qualitative* rather than a quantitative approach to scalability, as discussed in the literature review. This reflects the NU’s interest in developing the model whilst retaining its core or the ‘heart’ of its approach. With a focus on the human and relational aspects of the model, this study is not concerned therefore with replicating a particular technique or producing nurses and clients who are carbon copies of each other but on building conceptual understandings of the model which speak to ‘what is going on’ at a deeper level. In keeping with this, the methodological approach is underpinned by the idea of analytic and conceptual generalisability (Yin, 1994), in which robust and well-recognised methods are deployed in the service of uncovering new theoretical knowledge. This is akin to Denzin’s (1989) “universal singular” (p. 139) – the idea that a single instance contains universal themes – which when theorised can be applied in diverse ways in practice. Gomm *et al.*, (2011) also highlight the significance of “naturalistic generalization” (p. 2), whereby the applicability of research is determined not by the researcher – whose responsibility it is to provide ‘thick’ data (Geertz, 1973) – but by its readers, as I expand on below in relation to the collaboration with the FNP NU. Hollway (2015) argues from a psycho-social position that embodied subjectivity is *a way into* a critical understanding of objectivity, disrupting the objective/subjective binary. Therefore, the focus will be on

building ‘symbolic representation’ of the FNP model which contains a “diversity of dimensions and constituencies that are central to explanation” (Lewis and Ritchie, 2003, p. 269). This will be a dynamic process whereby new knowledge which emerges will refine my understanding of the whole as I “zoom in” on particulars and “zoom out” (Nicolini, 2009) to the whole and make links across FNP’s system levels.

Research questions

The study’s original research title and primary question were proposed by the collaborative team working on the funding bid, as FNP approached its ten-year anniversary. They show a reflective interest in the application of its model:

Scaling up and digging down: Exploring developmental issues arising in the implementation of the Family Nurse Partnership

What is the current and potential impact of the FNP model at micro, meso and macro system levels?

These bold, broad and somewhat existentially oriented ideas, were designed to assist FNP to transition to its next developmental phase.

The subsequent sub-questions were focused on scaling up the FNP model beyond the micro level, and the barriers which might limit this. Together these formed the basis of my research proposal developed between Feb 2016 and Oct 2016. Following the mini-viva process³, I narrowed the focus and addressed concerns about assumptions within the original questions. The revised focus was on expanding the explorative aspects of the study. This allowed me to adopt a more open, curious stance concerning the way that FNP practice was enacted and experienced. The revised primary research questions were:

What is the FNP model and how is it understood, operationalised and experienced in practice?

What are the opportunities and obstacles to operationalising the FNP model across the micro, meso and macro domains?

³ An internal examination involving feedback on the 15,000-word research proposal from two academics leading to permission to apply for ethical approval for fieldwork to begin

How can psycho-social research methods help to answer these questions?

As described in the introduction, the iterative nature of the study and the openness of the primary research questions allowed for more specific sub-questions to emerge during the study. These were:

- 1) What is/are FNP's primary task/s?
- 2) How does society's treatment and positioning of teenage parents play out within the FNP model?
- 3) What is the impact of austerity and managerialism on the FNP model?
- 4) What are the links between the psycho-social task involved in being a teenage/young parent and the operationalisation of the FNP model?
- 5) What are the conceptualisations of teenage/young parents within policy frameworks and how do these interact with conceptualisations of teenage parents within the FNP model? How are both of these conceptualisations informed by the lives and views of the teenage parents in this study?
- 6) What are the ethical considerations for clinical practice and policy making in this area?

In the light of the revisions described above, and to reflect an iterative and flexible study design I refigured the overall title to:

Digging down and scaling up: a psycho-social exploration of the Family Nurse Partnership Model.

By prefiguring 'digging down' ahead of 'scaling up', the title represents the design focus of paying close attention to one site, followed by experiences from other sites, as I will describe below.

Study design

During the first six months of the doctorate, I spent several days a week working from FNP's NU at the Tavistock Clinic. I learnt about the structure and roles, held one-to-one meetings with leaders (including David Olds), and observed events. With my assigned

local collaborator – an NU Clinical Educator, I developed the study design. We realised that to build relationships with participants over time (Ruch, 2016), the study would be best facilitated by deploying embedded research methods – observations and interviews - within one site. This site would then act as a case-study for understanding the operationalisation of the FNP model. I proposed to observe interactions and experiences at different levels of the organisational system (see Figure 1) using an ethnographic approach. This was chosen because of its focus on the “exploration of culture and subculture through the application of qualitative research methods designed to produce thick descriptions” (McNamara, 2009, p. 162).

Following on from the ethnographic observation, I proposed three focus groups from three additional FNP sites within England, to offer breadth and opportunities for data triangulation (Urwin and Sternberg, 2012) and comparability between the study sites. Each of the three focus groups was to be drawn a different source:

- 1) FNP clients and their close family or friends;
- 2) FNP clinical staff; and
- 3) Linked professionals – those who work closely with FNP but not directly involved in its delivery.

The design, therefore, had a two-stage structure. Stage 1, the ethnographic case study and interviews (over approximately nine months) and Stage 2, the focus groups (approximately three-months).

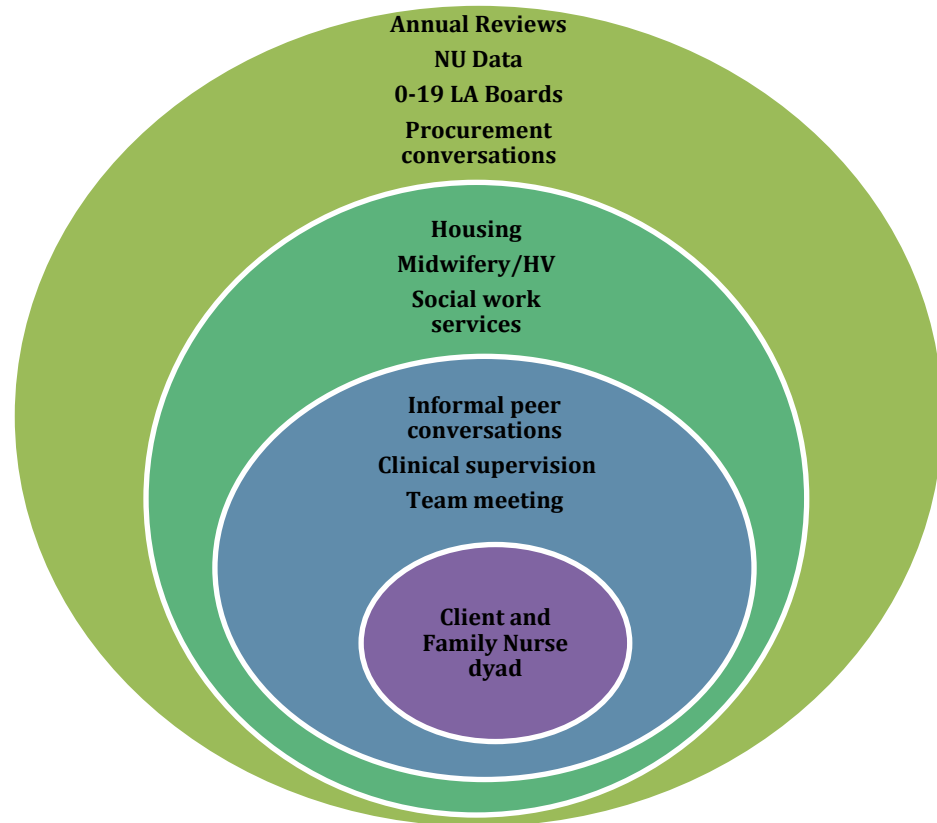


Figure 1: Case study sites of interest

Stage 1 was intended to facilitate an open and explorative approach. I adopted an opportunistic and naturalistic approach to observing activity including accompanying family nurses on home visits and office activity. This method mirrored the FNP model, also designed to facilitate responsive long-term relationships. An interest in the role that clients' relational networks play in the dissemination of the model - raised by the NU - saw this also included in my enquiry. The design was to be sufficiently flexible to allow me to follow interesting features horizontally (from family to family) and vertically (across system levels), as guided by reflective supervisory discussion.

In keeping with the iterative design, Stage 2 was later expanded to include an interview with each of the three supervisors located in the focus groups sites, as described explained further below.

Links to theory

The three meta-theories were foundational to this study design. The social constructionist perspective enabled a focus on listening to multiple perspectives, especially as the relationship between the phenomenon and the context were unclear (Yin, 1989). From a critical realist perspective, Sayer (cited in Easton, 2010) argues that when complex systems are the object of study, an iterative “cut and come again” case study approach helps avoid “causal misattributions given...the possibility that different mechanisms can cause the same events” (p. 124). The psycho-socially informed element provided the basis for the practice-near methods chosen, including self-reflection as a research tool (Cooper, 2009), and the analytic use of psychoanalytic ideas such as defences against anxiety applied to social contexts. Staying near to the ‘messiness’ of practice required space and time for listening, observing, asking questions, reflecting and thinking – in contrast to a more prescriptive method which might impose timescales and processes externally. All three theories supported my intention to move between psychological/internal processes and external social contexts to produce ‘thick description’ (Geertz, 1973). They were also foundational to my commitment – enabled by supervision and reflective journaling (Guba and Lincoln, 1985) – to give sustained intellectual, observational and affective attention to the FNP model.

To comply with the rigours of empirical research, the study design incorporated robust methods for ensuring its authenticity and reliability. Following Guba and Lincoln (1989) who highlight the importance of congruence between research outcomes and the experience of participants of the process, the collaboration with FNP led to regular meetings and consultation with NU senior leadership who formed one aspect of the ‘epistemic community’ (Ruggie, 1975) to support “judgements....about what counts both as empirical evidence and as a reasonable way of arriving at that judgement” (Elgin, 1999, cited in Doucet, 2012, p. 25). This is not to say that the NU was privileged over other participants, but, as members of the collaboration, they were in a unique position to be able to hear about emerging findings and comment on how these resonated with experiences of the wider FNP system. Their expertise in family nursing, supervision and clinical oversight of a large number of sites, enabled, for example,

relevant comparators with my data and the wider FNP system. The group was, however, respectful of the intellectual independence of the study and did not seek to steer its outcomes. Being able to draw upon their expertise during the selection of 'cases' (FNP sites), ensured that the process was systematic and justifiable. As the study progressed, 'member checks' (Guba and Lincoln, 1989) through regular discussion and sharing of emerging material (including a draft of the discussion chapter) confirmed the NU's belief in the validity and trustworthiness of the research process. A presentation of the study findings was met with similar confirmation that the methodology had produced 'thick descriptions' (Geertz, 1973) which both resonated and facilitated new ways of thinking about the FNP model. Likewise, participants within the sites who took part in the research spoke positively about the intention and process of this research. In April 2019 I visited the Stage 1 site to share an overview of the research outcomes. Nurses responded with feeling about my observations on the meaning of their work in the context of the hostility surrounding the lives of young parents, with one nurse commenting that she wished the commissioners could hear what I was saying. Their interest and enthusiasm, therefore, attested to the validity of the process.

Unfortunately, due to unforeseen circumstances, it was not possible to meet again with client participants. However, I hope in future to be able to present these findings to young parents and consider the implications with them.

Ethical considerations in the research design

As FNP is a health organisation based in the NHS, I applied for NHS ethical approval from the Health Research Association via the IRAS system. This was both a helpful process to prepare for the work, and, as I explain in the reflective account below, also an incredibly challenging experience.

My original proposal and subsequent NHS ethics application set out how I would gain ethical consent within three broad stages, namely:

- Site consent – agreement from the supervisor and staff to being willing to be part of the research in general;
- External agreement – agreement from relevant management gatekeepers and local NHS Research and Development agencies; and
- Participant consent – agreement from each participant, in most cases immediately before research activity took place.

The overriding principle from the outset was to provide participants with sufficient information and context in which to provide informed consent. I produced detailed information sheets and consent form (Appendix B) and discussed these with participants to ensure they understood and freely consented to taking part.

I thought very carefully about anonymity and confidentiality in the research design, particularly because of the small number of sites which were used and the type of qualitative data that I was hoping to collect. I introduced mechanisms to safeguard the identity of participants and, as the study progressed, made further changes to the design, in part to respond to participants' needs for anonymity, such as the inclusion of more interviews with supervisors at Stage 2. I ensured participants were not identifiable within this thesis by changing any identifying features. There was a particular imperative for internal confidentiality within FNP, which led to a commitment within the collaboration that participating sites would be revealed only on a 'need to know' basis.

The mini-viva raised the potential conflict of interests arising from FNP NU being study partners, funders and participants. Whilst there were already factors which mitigated against conflict in this area, it seemed pertinent to clarify boundaries within the partnership to facilitate the study's intellectual independence. This process led to a greater appreciation of the complexity inherent in the task of balancing the needs of the academy, the NU and myself; and acknowledgement that we should not assume that our interests would always be compatible. I attempted to re-position myself within the research design, less as a project manager and more as a trainee researcher with particular needs in relation to intellectual development and academic integrity.

Taking greater ownership of the project, I clarified the tripartite interests within the partnership as follows:

- To provide FNP's NU with useful research outcomes;
- To facilitate my pursuit of original knowledge; and
- To develop research skills within the standards set out by the University of Sussex.

The collaboration involved balancing several strands of relational, financial and ethical accountability. As my later discussion expands, this is reflective of the systems around the FNP model, which likewise involves multiple and complex lines of accountability in which ethical questions are at the forefront.

The early period of the study collaboration spent in discussion and relationship building provided a strong foundation from which open and meaningful discussion about these issues could take place. It led to a minor reconfiguration of the roles in which the FNP NU handed over the main direction of the study to me and committed to being facilitative participants in the study for the duration of the data gathering phase. This subtle but important shift supported me to be clearer about my position and gave me a greater sense of freedom to be open to unexpected aspects of the FNP model to emerge. This refiguring therefore supported the study to be more ethically aligned to its psycho-social framing.

Research methods

The study design included a range of psycho-social research 'tools' available for me to deploy iteratively. These reflective research methods were chosen for how they allowed me to learn about unconscious activity played out in the context of social systems. These are presented below, followed by a narrative reflection of my experience using them.

Psychoanalytically informed ethnographic observations

I chose non-participant ethnography as a 'gateway' method because of its explorative quality, and its focus on understanding people, their culture and practice using observation and interaction with their day-to-day activities (Ritchie and Lewis, 2003). As there was no extant qualitative data on the FNP model, I began by gaining exposure to activity where the FNP model is enacted, paying attention to affect and emotions. I recorded my observations in reflexive field notes which I wrote after the event rather than during an observation, to encourage participants to behave, as much as possible, as they 'usually' would, and to minimise the arousal of anxiety (Cooper, 2017).

I deployed a relationship-building approach, wanting participants to feel safe and trust me enough to exhibit something like their usual practice (Ruch, 2016). I was aware of the ethical issues with this approach, not least the tension between maintaining a 'neutral' position and the inevitable partiality of relational attachments – i.e. 'liking' or being 'liked' by some nurses more than others and making choices based on this. To mitigate this, I established role boundaries – for communicating the beginning and end of my involvement and not entering into relationships outside of the fieldwork. I acknowledged an intention to be 'as neutral as possible' – rather than maintaining a fantasy of complete neutrality, knowing that a psycho-socially informed 'in-out/out-in' position (Bradbury and Lichtenstein, 2000) enables thoughts and feelings to be considered as data rather than as a deviation from the 'real' research.

During home visits and formal office meetings, I adopted an observational stance that was based on my pedagogical experience of using the infant observation method during social work training (McMahon and Farnfield, 2004). Following Urwin and Sternberg (2012), I avoided informal conversations which characterised the rest of the ethnography, taking up a stance which involved paying close attention to activity, tuning into verbal, symbolic and non-verbal communication. The FNP site, rather than the mother-child dyad, was considered the constant 'case', but unlike with infant observation, observation was in diverse places and diverting from the weekly one-hour framework. To emulate the method, however, I tried to be consistent and equally available to all nurses within the site and where possible to observe home visits with

the same client more than once, to capitalise on the learning-over-time element. Although I did not have a weekly reflective group, I used reflective process notes and supervision sessions as a ‘good enough’ substitute for this process.

Reflexive writing

To support the reflective function of the methodology I used reflexive writing as a key part of my ethnographic observation method, recording my responses to specific encounters alongside descriptions of activity. This was to support my intention to critically consider taken-for-granted practice and constructions (Cunliffe, 2009), and to process my responses. My records were structured into columns with descriptive material on the left and affective/reflective material on the right. A small extract of a home visit record with a family nurse (J) is presented below:

Location	J' car, Y's home, J' car	
Purpose	Observation of home visit	
Time	3pm – 4.30pm	
Present	J, Y, G (Y's boyfriend), Y's mother, Y's father and a sister	
	Description	Reflection
Observations	J then asked Y if she had been able to look at any of the ‘facilitators’ that she had left with her last time she came. She had a new one also to introduce. J said she knew it probably felt a bit soon to be thinking about this, but had they thought about contraception? Y said she hadn't thought about it much, just about the coil. Y's father came downstairs. He overheard the discussion and made a quip about there not being any more babies.	I had a thought about what a big thing it must be in this family that Y was having a baby – the unexpectedness of it hit me and the psychological and emotional journey they must have been on felt huge, for them to be sitting there slightly teasing about Y having another baby.

Alongside this, I also kept a journal of the experiences and feelings that the fieldwork evoked. This was a way of noticing transferred feelings being played out within my own process, which I later used to support the data-analysis. It was an important part of my 'practice-near' (Cooper, 2009), immersive exposure to practice, helping me to contain and digest my affective responses so that they could be used as 'data', rather than being overwhelmed by them and 'acting them out' in other ways.

Free Association Narrative Interviews (FANI)

FANI, developed by Hollway and Jefferson (2000) involves an unstructured interview, in which participants are encouraged to free-associate and in which silences/nonverbal communication are attended to. Researchers ask minimal, open questions intended to stimulate participant-led discussion, to bring about new and hidden information via unexpected links between ideas, feelings and memories. Unlike Hollway and Jefferson, I did not use the method for biographical analysis of individual participants but as a means of learning about the organisational and social system. For example, data about the challenges that family nurses experienced was interrogated for what it could tell me about the context or system, rather than explained by analysing participants' psychological makeup.

The research design included the option of interviewing participants alone or, in the case of clients, with their family nurse, according to preference and pragmatics. Following the iterative mode, decisions about interviews (e.g. whom and when) were developed in response to the ethnography, with a broad aim of gaining data at micro, meso and macro system levels. To facilitate a relational method in which I would be least distracted, interviews were audio recorded.

Focus groups

In Stage 2, focus groups were used to broaden and diversify the data. Although I prepared a broad list of topics and questions (Appendix C), following my psycho-social approach, discussions were only loosely structured, following a free-associating approach, with attention paid to conscious and unconscious communication. I also

audio-recorded the focus group to allow me to concentrate on setting a facilitative and relational tone.

The fieldwork

To frame the narrative account, a brief description of the fieldwork and data set is set out below.

Stage 1

The ethnographic fieldwork began on in July 2017 and concluded mid-February 2018. The site was in a suburban area close to a major city. The 2011 census reveals a high proportion of economically inactive people, living with overcrowding and in lone parent households. It is a more ethnically diverse area than the national average, with approximately 40% White, 18% Other White, and 14% Black British.

The ethnography consisted of almost 100 observations of family nurse activity. A third were home visits and the remainder informal office discussion, team meetings, supervision sessions, client group events, NHS management meetings and external partnerships activity including one child protection conference. I conducted one-to-one interviews with the seven site staff members plus 17 interviews with other professionals including three external supervisors and one commissioner.

29 FNP mothers, four fathers, 23 children and 10 other family members (mostly maternal grandmothers) took part in home visit observations, with five families participating in more than one. I conducted nine interviews with FNP clients, involving eight mothers and three fathers. As half of these had not taken part in home visits, this added seven children. Most client interviews were conducted with a family nurse present, although one-to-one interviews were conducted with one father, one mother, and two grandmothers. Interviews were in clients' own homes, apart from one held in the community. They lasted approximately an hour.

Due to the nature of the study design, I did not collect detailed socio-economic details about participants. However, it is possible to provide an overview of relevant contextualising features. Reflecting the nursing and caregiving professions in general (Witz, 2013) and FNP (Robinson *et al.*, 1992), almost all professional participants in the study were female, with one male commissioner and two men present in observed management meetings. Likewise, the majority of client participants were female. In terms of ethnicity, the FNP staff team reflected the makeup of the site area as a whole, being an ethnically mixed team, with five White and two Black members of staff. Clients were mostly either White or Black British, with a small number of other ethnicities represented including Turkish and Eastern European. Nurses identified most clients as being working class, with two identified as middle class. Nurses were aged between the mid-30s and mid-50s, and shared a similar class background to each other – and myself – namely one of social mobility through education and professional training. Clients in the sample were aged between 17 and 19, although some graduated clients were slightly older.

Stage 2

The focus groups were held between February – March 2017. The stakeholder focus group was held in a post-industrial town in the North of England and the family nurse group in a university town. In response to the rural geography of the site, I held two client groups - one in the north and one in the south of the county. There were 33 participants across the four focus groups. All participants were female apart from a father who attended one of the client focus groups. Stage 2 was much less ethnically diverse, with mostly White British participants and one Asian and one Black British client participant, reflecting the smaller sample group and the reduced diversity within the population in general within those areas. There was a similar social class make up to Stage 1 in terms of both clients and professionals.

Figure 2 below presents an overview of the data sample, structured in the same way as it is within the findings chapters for ease of cross-referencing.

FNP clients and their parents

FNP clients and partners	Interviews	Focus groups	Observations notes
TOTAL	9	2 groups (11 participants)	34

FNP client linked people (i.e. grandparents)	Interviews	Observations notes
TOTAL	2	7

Family nurses and supervisors

FNP Staff	Interviews	Focus Groups	Observation notes
TOTAL	10	1 group (9 participants)	60

Wider professional participants

Linked professionals with an FNP specific role (e.g. clinical supervisor)	Interviews	Observation notes
TOTAL	4	5

Linked professionals without an FNP specific role (e.g. midwife)	Interviews	Focus Groups	Observation notes
TOTAL	5	1 group (6 participants)	2

FNP NU	Interviews
TOTAL	3

Figure 2: Overview of the data set

Reflective account

Choosing sites

The criteria for choosing the Stage 1 site were both conceptual (being a fairly 'typical' FNP team as defined by its members) and pragmatic (stable, amenable, accessible, available). I worked with my NU link colleague who, in consultation with the clinical leadership team identified a short-list of three sites matching the criteria. Of these, the collaboration team chose the site most likely to provide as 'ordinary' an experience as possible.

I began 'in principle' discussions in the spring of 2017 and later visited the team. However, a subsequent change in supervisor led to the NU advising against this option due to the instability that this created in the management structure. In the interim period, another site had become eligible. I approached this site and the team provided in-principle go ahead, which enabled me to move forward with the necessary ethical approval requests.

Site selection for Stage 2 was undertaken similarly, with sample criteria being agreed by the collaboration and a short-list produced by the clinical lead. We were aiming for three sites which would provide contrasting contexts in terms of region, culture, length of existence, governance structure etc. The site would also need to be amenable and not be already involved in other FNP related development projects. The local knowledge and established relationships of the NU clinical team were invaluable in steering this process and brokering contact with sites, which began in the autumn of 2017. Each site agreed to take part.

Limitation of the sample selection

A pragmatic issue dictating sample decisions was time. A delay in gaining ethical approval caused a four-month drift on an already ambitious three-year timeframe. At Stage 2 we selected sites according to whether there was a reasonable chance of good attendance, meaning that the data could be skewed towards participants who were engaged and therefore positive about FNP. This is offset by the ethnography which,

being at a much slower pace, allowed the time needed to hear divergent voices, such as stakeholders who did not find the service helpful.

When the data from both stages were brought together, I found consensus - particularly in terms of client voices - and divergence - mostly in the views of professionals. On the whole, straightforwardly 'positive' views from professionals were found in the focus group sites, with more mixed views from the ethnography. This may be due to the opportunity to dig deeper available in Stage 1, or other factors explored in Chapter Six. Nevertheless, I resisted the idea that views were either 'positive' or 'negative', in favour of staying close to the explorative rather than evaluative focus of the research questions.

NHS ethical approval

The study required NHS ethical using the Health Research Authority (HRA) IRAS scheme. Having gained academic approval from the University of Sussex in November 2016, my intention was to beginning fieldwork the following spring. The process proved to be far more time consuming and problematic than anticipated. Anecdotally I had heard about the bureaucratic and unwieldy nature of the process. However, it is hard to underestimate how stressful it was to navigate the terminology and acronyms, conflicting advice, and vast amounts of information required - including a research protocol (25,000 words), and twenty separate documents.

Apart from the volume of information requested, FNP did not fit within the HRA's categorisation system. Therefore, I could not answer many of the closed questions on the lengthy online form, but leaving them blank precluded submission. Trying to find out what to do resulted in this type of confusing answer:

Dear Rachel,

Thank you for your enquiry.

If the FNP sites are only identifying potential participants they could be PICs and not research sites. Please see further guidance at <http://www.hra.nhs.uk/resources/after-you-apply/participant-identification-centres/>.

If you intend to use NHS sites, PICs or research sites, all these would require NHS Management Permissions. Please list all sites in Part C of the IRAS form.

Regards

Queries Line

Eventually, with moral support from my supervisor, I produced a ‘good enough’ description of the project, within the confines of the form. I was required to book an appointment with a Research and Ethics Committee (REC) on the same day as submitting, which I finally did in February 2017. The project was considered low-risk and was therefore sent to a REC which did not require my attendance. Having felt like I was battling against a huge bureaucratic machine for several months, I was delighted when the committee responded affirmatively on 1st March with positive comments about the research design. After two months, a letter of approval came from the HRA which allowed me to begin the next stage, namely asking permission from the local Research and Development (R&D) department. I was dismayed to find that this would take another six weeks and involved re-submitting all the IRAS documentation to the R&D department, along with some additional documentation. By then I felt I was caught up in a sort of manic mythological quest – my determination and tenacity tested to the extreme. The apparent irrelevance of the requests for information caused me to wonder if I would ever attain the ‘holy grail’ of actually starting the data-collection. Eventually, the final hurdle was getting a form signed, in lieu of my NHS honorary contract. When the HR department could not locate my contract (paper records having been taken away for digitalising), I took my copy to them and stood pleadingly over an officer as she signed the form. The entire process had taken eight months.

Ironically, therefore, the ethics approval process led to some less than ideal pragmatic choices and created further ethical dilemmas. My experience was of a faceless ethics ‘machine’ which felt oppressive, demotivating and very anxiety-provoking. I felt tiny, peculiar and at times quite overwhelmed. Whilst waiting – in which I felt in limbo, unsure when it would end - I attended a presentation by a doctoral student who had taken over a year to gain her NHS ethical approval. A friend told me that “going through” IRAS had brought her closer than at any other time in her career to abandoning a work task – a career which included completing medical school and several gruelling years of post-qualifying specialist training. These fuelled my worries about whether as a ‘layperson’, what I was trying to do was feasible within the already quite ambitious timescales of the project.

When I did finally reach the other side, I was so relieved that it was hard to reflect. Writing this piece and looking back at emails to establish timelines invokes similar feelings of resistance – in an unconscious gesture of agreement with this, at the end of reviewing the last sentence I inadvertently pressed a button on my computer which turned it off. From the start, how long it would take to gain NHS ethical approval was a ‘known unknown’⁴. However, I had not anticipated how daunting it would be to keep believing that I would get out of the bureaucratic maze. Whilst I was grateful for the way it provided a checklist of ethics documentation the process was incredibly discordant with the actual risks of the project and failed to address some of the more complex issues discussed below. It is most useful in retrospect, for providing me with a contextualising experience of the field of study. This was no abstract learning – it had a considerable tangible impact on the research. For example, in the time lapse between REC and HRA approval, a change of supervisor in the original site meant a new one needed to be found. This alerted me to the significance of the supervisor role - later born out within the fieldwork. The timeframe left for approaching the new site meant that a nurse on sick leave had to be consulted before I had the chance to meet her. Later, I wondered if this less than ideal beginning had played out in her attitude towards the research.

Further reflection on the process yields other insights. My ‘limbo’ feelings, for example, had interesting parallels to the accounts that some nurses gave within one site during the beginning stages of the project. With no structures in place, they had to wait several months before seeing clients and therefore had very little to do. The anxiety and mania associated with this time resonated with me and drew my attention to how organisational processes can cause surreal forms of waiting, which give rise to feelings of powerlessness. This unstructured space can be difficult to tolerate, akin to Baraister’s (2017) idea of temporal tropes, inspired by the Freudian concept of *nachträglichkeit*⁵ (Ross, 2017). Here the expected linearity between time and task are suspended, so that meaning can only be conferred retroactively – as I am doing here.

⁴ A concept derived from the popular tool the Johari Window used in organisational psychology and education developed by Luft and Ingham, (1955).

⁵ Deferred action

This contrasts with the more generative and containing idea of time-suspension and space, explored later in this thesis, in relation to the practice of holding something off on behalf of others for their growth.

I also found parallels with the exasperation that nurses felt when dealing with bureaucratic NHS systems (be they IT, data or HR related). Similar features included the lack of congruence between organisational processes and 'real-life/work' and a paradoxical sense of dependency and abandonment by the organisational system. These processes, rather than being facilitative of the work, often became things or 'machines' which needed appeasing or navigating – a part of their role largely undocumented despite taking up considerable time. Applying for additional Stage 2 permissions served to amplify the parallels further. For example, the team were undergoing office re-location. This generated feelings of anger and powerlessness about a system that was not able to hold in mind the clinical or professional needs of those affected.

Without wanting to overstate the parallels or appropriate the situation of those much more structurally disempowered, I also felt like I understood in a new way something of the experiences of service users caught in unpredictable welfare systems when waiting on decisions which will significantly impact their lives. Applying for ethical approval, therefore, had the unintended consequence of deepening my empathy for research participants as deliverers and users of services in their interaction with administrative processes.

Stage 1 reflections

In the study design, I set out how I would mitigate the potential ethical considerations raised by the use of psycho-social research methods. This included being clear with participants that I was interested primarily in their FNP-related experiences and not expecting them to share painful memories of private experiences. However, conversations inevitably touched on difficult experiences – like when teenagers recounted being treated with hostility. Rather than being distressed by the process however, participants felt inclined to ask my permission to share these personal non-

FNP experiences, which I gave because this seemed more authentic and valuable. These moments constituted a form of thinking-in-action (Schön, 1983), where I drew on my social worker training and experience to provide a space in which participants' difficult feelings could be thought about. Participants who expressed emotion seemed to find this helpful, in the context of us having established a trusting relationship.

I had explained to the team that I would respect their need for confidentiality and anonymity. They sometimes sought reassurance however, that I would not include material within this thesis that would feel exposing. Whilst generally they seemed to trust me with delicate or sensitive information, there were a few exceptions. One participant, for example, declined to consent to me observing her supervision – because it was a place for “letting off steam”. Likewise, one of the family nurses seemed reluctant to allow me to observe her on many home visits, giving the impression that this was because she was establishing new relationships and felt an observer might disrupt this process. Speaking often about clients she wished I could have met, I wondered if this nurse was keen to show me only ‘successful’ relationships. I was disappointed and frustrated, but in both cases accepted this as their choice and compensated through having office-based discussions instead.

To deploy the iterative approach, I had imagined that the data would, at some level, ‘make sense’ to me and that I would feel somewhat in control of the process of knowing what I was learning about, as I learnt it. I had thought that the main ethical risks might be related to my ability to resist unconscious bias and avoid being uncritically ‘subjective’ in my choice of methods or research participants. The reality of my inside/outside position made this difficult and I found it hard to think about what I was learning sufficiently to be able to deliberately pursue a particular thread. The experience ‘filled me up’ leaving little room to move away from an opportunistic mode. I felt anxious about the ‘lost’ time, and an urge to get as much data as possible. When it came to selecting interviewees, this was compounded by a desire not to enliven competitive feelings within the team, so that I spoke to everyone.

Through supervisory support and reflection, I was able to apply the iterative method more deliberately within the ethnography with some support. For example, I identified an interest in the supervisor role as pivotal to nurses' containment and support. This led to a decision to observe the team supervisor more closely over a few weeks, which provided me with an appreciation of her role within the local context. I also identified the need to seek out particular external stakeholders, especially social workers. I was reliant on nurses to broker these relationships and several attempted to support me in this. The struggle I had to engage external stakeholders reflects the team's own experiences of engaging the wider welfare system. As with other access challenges, it serves as information about the way that the model is enacted within that local area.

When it came to client and stakeholder interviews, I was also able to be more reflective and with my supervisors identified gaps in the data to ensure that I did not uncritically gather voices from a singularity of perspectives. I tried to ensure that at least one client from each of the nurses was interviewed and that they reflected as far possible the diversity represented within the site. Asking nurses to facilitate interviews raised further ethical issues. For example, a nurse who was reluctant for me to observe home visits saw interviews as a means of reuniting with 'graduated' clients, whom she would not otherwise have contact with. This gave me something with which I could 'trade' with this nurse, but I worried about exploiting her sense of loss and reviving difficult feelings for the purposes of research. It was also a relief to have something to offer beyond being someone friendly who tries not to be too annoying, which took considerable energy to maintain. To support my reflective process, I drew on regular supervisory accountability and journaling. I also drew on my professional experience of withstanding, reflecting on and learning from the unconscious projections of others. In this way, I tried to stay as aware as possible of my motives for the choices I made.

Although the nurses had consented to the research, I found myself wondering about their more ambivalent feelings about being observed. On my second day, for example, I received a message saying that as no one was in the office, I need not come in. Later I connected this to rejection that nurses felt when clients were not in for visits. This led

to a practice by some of phoning clients immediately before a visit to avoid “wasted” visits. Within psychoanalytic clinical practice, a client missing a meeting can be considered in terms of communicating avoidant feelings (Roughton, 1993). Similarly, in the case of my second-day experience, I wondered whether there was some unconscious communication of vulnerability generated by my gaze, partly transferred from clients who might understandably sometimes also want to avoid the gaze of nurses. On another occasion when the office was full, I sat on the floor. This again caused me to reflect on the possibility that nurses might be communicating a sense of being too full-up to be observed, and also to wonder if they were sharing, albeit unconsciously, transferred feelings of humiliation and illegitimacy because these feelings came through strongly in the narratives of clients.

During the design phase, I had considered whether nurses would find my embedded, relationship-based approach obtrusive. In general, this did not transpire to be an issue, with all of the staff expressing in different ways the benefit they found from my being there. I was however sensitive to the team’s wish to sometimes hold private conversations and sometimes felt like an intruder, unsure of my position. Negotiating where to sit every day was particularly delicate. I would poke my head around the doors of the two shared offices and very quickly gauge where to sit, asking myself several questions ranging from the pragmatic to the affective. Was there a spare desk? How did the person in the room *feel* about me joining them? Which room would be most advantageous for filling in data gaps? Underneath it all was a question about who I *wanted* to sit with, followed by guilt about this not being a legitimate reason for choosing where to sit. Whilst I know that a psycho-social framework allows researchers to draw on uncomfortable feelings to learn about the field of study, in reality, it was sometimes difficult to simply observe my own defences. When, for example, two people left the room to hold a whispered conversation next door, I felt paranoid and keen to avoid a repeat occurrence. My reflective journal and supervision discussions, along with practice experiences of working professionally within groups supported me in managing these encounters. However, it remained the case that there were hundreds of complex micro-decisions which involved a lively use of my psycho-social, intellectual, practice and relational faculties.

The many hours of office observations that I undertook were valuable for learning about nurses' thoughts and feelings about the FNP model, how they became involved and how it affected their lives. The levels of access to clients they facilitated and the richness of the interview data were testament to the strength of relationships we developed. However, this was not always easily won, and, as with negotiating where to sit, negotiating accompanying nurses on visits was also a highly complex business. Some nurses were very open, whilst others were much more reticent. Although I tried to pursue visits with all nurses equally, their varied responses made this difficult. One nurse spent many weeks arranging visits with me, only for most of them to be cancelled by her clients. Others negotiated access by calling them on the day to ask permission. During a visit I would have space to introduce myself, explain the research and gain consent. This worked well generally, apart from with one client who gave verbal consent but then declined to sign the form, leaving me confused about what exactly she had thought she was consenting to before.

At home visits it was often unclear where I should place myself, but where possible I tried not to sit between nurse and client. I sometimes felt in the way and awkward and noticed a strong urge to be helpful. On one occasion, which feels quite embarrassing to recount, I offered my scarf when a nurse and her client were looking for something soft to put in the weighing scales to make it more comfortable for a baby. The nurse responded saying that I would not want the baby to mess my scarf. Later I wondered if she had said this to protect me from the 'real' reason, namely that it was unhygienic for a baby to be placed on an observers personal item – especially one worn close to the face. I felt I had made an 'unprofessional' error of judgement which left me feeling quite unnerved as to why I acted out my urge to get involved and misread the boundaries. It was probably the most pronounced example of moments throughout the ethnography when I felt a confusing mix of gratitude, guilt and shame. I believe now that this experience conveyed to me in a very embodied way the feelings that nurses often expressed: gratitude for having a job which enabled them to work relationally, a sense of responsibility for this and a strong wish to be helpful. This wish had a shadow side of shame or guilt when 'being helpful' was not always available to

them, leading to confusion about the boundaries of the role, as explored in chapter five.

Reflecting in this way on my feelings about the data – taking a psycho-social sensibility - enabled me to be curious about what was ‘going on’ in what felt like a full and generative way. Forming close relationships within the ethnographic setting was extremely useful for getting a practice-near (Cooper, 2009) understanding of what was going on. I spend considerable time with nurses alone, travelling to and from visits. Nurses shared their views about their clients, other team members and sometimes their personal lives too. As nurses trusted me more, the level of disclosure increased. Sometimes I felt that I provided a confessional space which resulted in being something of a confidant, holding a great deal of sensitive information. Maintaining relational safety through this process required maintaining good boundaries, including not sharing things told to me in trust, either during the fieldwork or in the writing up of this thesis. Although participants sometimes explicitly prefaced information with “this is not for your research, but...”, many times I relied on my ethical sensibilities and empathy skills to imagine how I would feel as the participant, to gauge how to handle information. However, this remained a source of ethical angst for me as I grappled with a sense of duty to tell the ‘truth’, the multi-layered motives of participants in revealing information to me, and my duty to safeguard participants from exposure. I wondered how I would be able to talk about these things in a way that was generous and inclusive, whilst also being honest.

After a few weeks, I felt very ‘full-up’ of what felt like sometimes quite undigested feelings and it was at times difficult to be clear in my own mind about my boundaries. The team often expressed their gratitude to me and gave me gifts (on my birthday for example) and told me that I felt like “part of the team”. Their appreciation made me feel guilty: they felt I was giving them something when I felt that in reality I was ‘using’ their experiences as my data. I worried too that in providing a reflective containing space, I was in fact trespassing on someone else’s role. I was also plagued by a feeling that my academic researcher boundaries were too loose - was I too warm and friendly? Did I give ‘too much’ relationally, to get what I needed? An extract from my

diary just a month in, reveals something of how this tumult. Tellingly the narrative style has reduced to note form:

July 27th

My own insecurity paralleling the FN's –
unclear about boundaries
feeling overwhelmed

I feel an urge to problem solve – very strong
“Sitting on my hands” – real challenge.

My role in witnessing safeguarding issues - worrying about her judgement.
Needing to digest, not just stuff, more things in all the time.

2nd August

Feeling quite full of FNP visits, relationships, observations, ideas, thoughts, feelings...

Whilst these feelings yielded rich information about the field, they took their toll.

During a supervision session early in the ethnographic fieldwork stage, my supervisor suggested I would benefit from additional space to process the feelings being generated by the research, so I decided to see a weekly psychotherapist between July 2017 and July 2018. This space prevented me from being overwhelmed and provided a balance for all the listening and absorbing I was doing. I was able to carry on with an open, non-judgemental listening stance, though it was still at times very challenging, and I struggled not to blame and doubt myself in response to my feelings, rather than to be curious about them. Like some of the nurses and clients I encountered during the research, I wondered if I was ‘getting it right’ and whether I was ‘good enough’ for the task.

This extract from the poem *October* by Don Thompson (2010) resonated with me:

I used to think the land
had something to say to us
back when wildflower
would come right up to your hand
as if they were tame

Sooner or later I thought
the wind would begin to make sense
if I listened hard
and took notes religiously.
That was spring.

Now I'm not so sure...

Somewhat like the nurses when they started out with FNP and the poet, I was full of optimism at the beginning about what I would find and the ease with which new knowledge would reveal itself to me. The reality was much less clear-cut, with thoughts and feelings which were hard to organise, make sense of or learn from. My initial response, also I believe like the nurses, was to wonder if I was sufficiently up to the task.

Knowing that my emotional experiences could be useful as 'data' for reflecting on psycho-social experiences in the field did not, I discovered, provide any sort of short-cut to knowledge. It turned out that 'research feelings' *feel* just like any other feelings *feel*, and no amount of intellectualising really helps with this in the moment of experience – which, paradoxically is the point. For my emotions to do the work I hoped they would, I needed to actually experience them. I also had to trust the reflective process which involved self-observing through discussion and writing. Slowly, this enabled me to acknowledge my feelings sufficiently to be able to learn from them and to start to see how absorbing and listening to others might have caused some of their unconscious feelings to be transferred to me (Hollway and Jefferson, 2000).

Writing this reflection, I can see mirroring patterns around boundaries, accountability and paradoxical feelings. My methodological approach involved developing embodied knowledge, empathy and a humane attitude towards my research participants, which guided me away from the sort of blaming or splitting that this topic can give rise to – as I discuss later in this thesis. I experienced, alongside nurses, the emotional labour (Hochschild, 1983) involved in taking up a relational task with optimism, only to feel overwhelmed by the level of need and conflicted by a sense of loyalty and responsibility about how best to respond to this. I understand some of the fear of judgement and shame that runs through the data set, and the double suffering (Frost and Hoggett, 2008) of these feelings, which by their very nature seem un-shareable. I no longer feel overwhelmed because I had good enough containing structures which allowed me to be honest and curious about my feelings, allowing deep learning to transpire.

In using this material, I was conscious that psychoanalytic and psycho-social research is sometimes ethically problematic, due to way that interpretations are presented with authority and without a client or participant's explicit knowledge (Hook, 2008). To avoid this, I applied the same interpretive lens to others as I used with myself which was to consider feelings and actions as symptomatic of collective psychic activity within the social context (Jervis, 2014). This allowed me to deploy a strengths-based lens, in which I held a position of curiosity about even the most difficult data, not blaming or splitting, but seeking to develop a psycho-social sensibility which was ethically compassionate and generative (Redman, 2016).

The FNP model is heavily reliant on relationships. A methodology which pivots on relationships as the means of uncovering data, therefore, proved to be wholly appropriate. It enabled congruence concerning methodological trustworthiness and confirmability, transferability and dependability of the data generated, because, as Gilgun (2012) explains, this type of knowledge, if handled within a robust analytic framework:

Is not information that simply passes through the central processors of our brains. It also arises from our hearts and often our deeply-held emotions. Understandings gained through an engagement of heart and mind have an immediacy that potentially connects to the hearts and minds of audiences. (p. 121)

In both practice and research, as in life, relationships can be complex, messy, full of conflicting feelings. To learn more about the specific ways in which these things are mobilised within FNP, it was necessary for me to 'get in the water' as it were, rather than watch from the side. This was a 'feelings-near' research in which I was close to unprocessed and complex unconscious dynamics. At the same time, it was an incredible privilege to be given the thoughts and feelings of participants to work with. The level of intimate access I was given, led to some very rich and diverse data and will, I believe, lead to meaningful new ways of understanding the FNP model.

Stage 2 reflections

The second stage of the research involved using research-focused psycho-social skills in some quite different ways. One difference was the decision to work with a co-facilitator from the NU. As a collaboration team, we felt that having a second person to support the focus groups would greatly enhance my ability to focus on facilitation. Discussing the risks, we felt that only the group involving FNP nurses could be unduly influenced by someone from the NU being there, and so I led this one alone. In the others, it was very useful to have someone to welcoming participants and attend to practical issues, freeing me up to provide a quality of attention during the groups that would not otherwise have been possible. My co-facilitator acted as scribe during some of the reflective exercises and her presence put people at ease at the start and end of the groups. Attending to these aspects was in keeping with my methodological intention to create a containing, respectful and relationally safe space in which participants would feel able to trust me and share their experiences with a degree of honesty, without worrying about 'right' answers.

In preparation for the groups, I drew up a plan with a loose script for the preamble and a list of prompts (Appendix C). These were open ended questions informed by my learning at Stage 1. With my supervisor, I grouped, and colour coded them according to whether they would be best used when participants seemed nervous, showed more confidence or if they seemed able to handle more challenging material. In contrast to Stage 1, I felt much more confident in my researcher role and enjoyed the relational and intellectual challenge which the groups provided. The discussions were rich and very fruitful. Another surprising element was my co-facilitator's observations of how psycho-social practice-informed research methods had played out during the groups. Speaking in particular about the client-focused groups, her view was that by deploying empathetic, relational and therapeutic skills in the service of the research process, the groups had yielded much richer material than she had seen in similar forums designed to gather the views of clients. I was interested in her methodological insights about how practice skills can be brought to bear in research settings. These include sensitive listening, asking follow-up questions, holding silence, being 'genuine', noticing body language, wondering about feelings in the room, reflecting, summarising and affirming

contributions. Deployed in this context they helped to create a containing, emotionally available space which facilitated the research process.

This is not to say that the groups were without challenges. The second client focus group was much harder to facilitate mostly because of the needs of the young children in the group. I became anxious about maintaining safety when a little girl nearly stamped on the head of a baby and another tipped a box of toy bricks over her own head, causing her to sob loudly for quite some time. In the same group, several participants instigated a smoking break half-way through, and one group member surprised me by leaving before the agreed end time. It was challenging to hold the structure of the group, whilst also being flexible to everyone's needs – children, adults, those who left and then returned, those who stayed. Some individuals were particularly hard to engage, and I had to contend with feeling that I might seem ridiculous/annoying and 'out of touch' to them. Without my NU support I could have become quite overwhelmed by these feelings, but I drew on her calmness and containing presence to overcome my anxious pre-occupations sufficiently to continue to try to connect with the group and to think about the meanings that leaving and returning might have for some members. By the end, everyone in the group had engaged in a less defended way, and I had learnt more about these young parents' wish to be together in less formal settings.

The two research stages, therefore, provided contrasting experiences. Together they provided rich material for understanding the FNP model and the role of psycho-socially informed research methods in achieving this end. The fieldwork concluded with interviews with the NU leadership team in April 2018. In keeping with the slippage caused by the delay in gaining ethical approval, this was three months behind schedule. As the data summary (Figure 2) demonstrates, the fieldwork yielded a large and diverse data set consisting of interviews, focus-groups, ethnographic notes and a reflective diary. I then subjected the data to psycho-socially informed analysis, as described below.

Data analysis

In May 2018 I started analysing the interview material using the Listening Guide (LG) (Gilligan, 2015). I was drawn to the LG's staged approach, in which layers of meaning are built up by applying different 'frames' in a process of simultaneously listening and reading the same piece of data several times. Aware that the FNP model is a complex social phenomenon, and mindful of the dangers of splitting and polarisations, I chose an approach which I hoped would keep me as near as possible to the multi-layered complex 'whole' of the FNP model, rather than one which would fracture and systematise it into themes and codes and 'key words'. The LG is not overtly psycho-social, but the way in which individual and social dimensions are recognised and explored in relation to one another, as well as the LG's feminist and emancipatory underpinnings in the pursuit of marginalised voices (Brown, 1997), convinced me that it was a fitting choice. I was also drawn to how the method includes the production of 'I poems' – distilled abstractions of research data around the 'I' statements - because of my interest in language and creative research methods. As far as I am aware the LG is not usually used in studies of organisational systems, so after reading and speaking to experienced colleagues, I produced my own adapted 'guide' (Appendix D), refining the process after the first few attempts.

My adapted listening guide ran along the following lines:

- I organised the interview script in landscape format, splitting the page into two columns, with words on the left and blank space on the right-hand side of the page (see Appendix D for images of completed scripts).
- I listened to the transcript of the interview with the script before me, marking a new idea or theme, and writing notes in the margins. On the first reading I was particularly trying to trace the main ideas, and also pay attention to my responses to the material. This required stopping the recording frequently and going back to listen again to something that had caught my attention.
- After the first listen I used a spreadsheet to record all of the individual themes and reflexivity questions/feelings/ideas. Using the interview name in code across the top and the theme/idea along the side, I was able to track those

ideas that interviews had in common. This table later helped to shape the structure of the findings chapters and with locating data to support the analysis.

- Having done this, I repeated the process, but this time I listened for 'I' statements (including 'me', 'you' and 'we' if relevant). I marked these on the script using different colour pens to those used in the first reading (see Appendix D for images of a script). This also involved frequent stopping the recording and returning to sections to glean as much understanding as possible.
- After the second reading, I entered data into a document set up for recording any aspects of the data relating to relationships. This was a simple a table with a column for indicating the source on the left and a column for the data on the right. I pulled out anything in the interview that had either overtly referred to relationships, or which had alluded to them. Typically, one interview created 8 items. See Appendix D for an example.
- I also organised the data in a third table in which I recorded how the interview answered the research questions. An example of this is found in Appendix D. The purpose of this was to keep my attention on the research questions as I was listening to the data in depth.
- Finally, I produced an 'I' poem or series of pomes or abstractions based on the data. This involved reviewing the data transcript as a whole and selecting out sections that stood out to me. They were often those sections which were by now very colourful because they had generated thoughts and ideas during the double listening process.

Creating an 'I' poem

The method I followed for producing I 'poems' was based on the original process informed by my prose and poetry writing practices. When I write I pay attention to and work with both the words and the blank spaces on the page, such that the spaces support the pace and emphasis that the reader gives to the words. A detailed description of my method for creating 'I' poems is set out below:

- I review the highlighted areas on the script
- I then chose a section which has energy – i.e. which contains an idea or theme that I am interested in exploring further or which stands out for whatever reason;
- Next, I decide on exactly where the section will start and end and cut and paste that section into a new document;
- Starting with the first line, I begin by adding space and pauses around the words as I read them, using the cursor or the return button do this. I also remove unnecessary commas and full-stops and joining words. The original LG suggests more of this type of ‘cleaning up’ but I find the smaller words often give the words verbatim energy that I want to retrain;
- I read again for flow and movement, refraining from adding words or changing the sequence, but if needed, adding spaces to slow the reading of the text further.
- Finally, I read again, looking for a phrase which seems to capture the essence of the poem or holds its overall meaning and use that as its title.
- Appendix E contains an example of an I poem.

Creating ‘I’ poems helped me to focus in considerable depth on a small sample of scripts. Listening/reading several times and with different emphases to a sense of immersion in the data. In addition, producing three secondary data documents from these readings gave me a basis from which I could analyse the rest of the data – as described below.

By mid-June, I had completed this process for nine interviews and one observation – the latter being an experiment to see how it would work with different data sources. By categorising my data according to its source and type in a data analysis tracker, I made sure that the small sample was as representative as possible of the wider data set i.e. a variety of clients (gender, ethnicity and nurse), and a variety of professionals and clients had been included in the first stage of analysis. This process allowed me to step from the fieldwork and to home in on particular data, providing a depth of appreciation for the experiences of clients in particular. Producing ‘poems’ was a rich

experience as I sought to enter into the words and worlds of participants. Without the social dimension that had been there during the fieldwork, I was able to think about the material in a different and more sustained way.

This process was also very time consuming, and I was aware of the need to represent not only the depth but also the breadth within the data set. In keeping with my iterative approach, my supervisor and I agreed that I would use this initial LG analysis as a way of 'digging down' into the data to inform the next phase which would take a broader perspective – a 'scaling up' of the first phase's insights. I therefore worked with the ten LG analyses together through a mind-mapping process, building up a frame of meaning on which to 'hang' the rest of the data. This process involved printing out and cutting up the words/ideas/features from the LG analysis, which I had recorded in a spreadsheet. Having produced a list of over 450 data words/ideas/features I then set about working with these to come up with a summary map of the ideas present. I took two flip-chart pages – labelling one 'client generated data' and the other 'professional generated data' – and began to group the words according to how they related to one another. For a week I worked in this way, moving backwards and forwards between the pages in front of me and relevant literature which helped me to solidify the 'clustering' process (Appendix F). As clusters emerged, I tentatively labelled them and then later solidified these into mind-maps shapes, drawing links between the areas. From this, I produced electronic versions of the categories (Appendix G).

Reflecting on the process, my supervisor and I discussed how the client map is sparser and less 'cluttered' than the professional map. This is partly down to how my own reflections are contained on the professional map, as well the organisationally oriented nature of this study (compared say, to an ethnographic observation of the life of young parents), meaning that the data gathered is necessarily focused on complexity at this level. It also speaks to how organisational issues, like the commissioning agenda or licencing requirements, are often mediated by family nurses on behalf of clients, to enable them to focus on their parental and domestic concerns. The maps mirror one another and together are an attempt to consider the data as a

whole, whilst also recognising the primary boundary between those who deliver services and those who receive those services as clients. They capture something of the complexity of the FNP model including the interests of multiple stakeholders and lines of accountability as developed in later chapters.

The clustering of words to produce the maps was an absorbing process. At times I felt as if I was in something of an intuitive, dreamlike state. Other times my superego got involved and complained that I should be less dreamlike and more focused and rational. In my reflective notes, an image/metaphor emerged:

It feels like I'm on a countryside pathway where there are thick overgrown brambles and nettles ahead of me. To get where I need to go, the brambles will have to be cut down, but instead of getting on with this task, I find myself sitting down by the side of the path and just staring up at the sky.

Considering the idea of transference within social systems – as discussed in the last chapter - I then explore in my writing the possibility that this could reflect tension within the data. Is there sometimes a pressure on family nurses to 'get on with a task' as exemplified by the manualised educative programme material? Do the more reflective, meandering, 'being alongside' relational aspects of the role feel unproductive in contrast, and harder to justify? How do 'sitting down' and 'slashing nettles' relate to one another? I carried these questions into other parts of the data and continued to draw on my own process as the analysis progressed.

In addition to reflexive journaling, I wrote narrative summaries of the maps, to continually draw my attention back to the whole data set. In keeping with this, I invited a colleague experienced in psycho-social research to produce a free-association narrative response to them. This was very helpful to alert me to particular aspects of the data which I had not previously noticed, for example, the role of baby weighing within the FNP model, as explored in later chapters.

I then used the mind-maps as templates – one for service users and one for professionals (Appendix G). The templates contained four main headings which

summarised the information arising from the LG phase of analysis. I drew the relevant headings on a large sheet and as I read or listened to each piece of the data, I recorded phrases, ideas and words according to where they fitted into or around the template headings. If they introduced a new concept that did not fit under these headings, I would note this too. I was very thorough, meaning that the mind-maps became rich secondary data (Appendix H). As a process, this enabled me to digest the whole data set within a short time frame and make links across the whole data set. To conclude this process, I undertook a free-writing exercise around the question “What is the data telling me?” By this point, I was surrounded by the data - materially, psychologically and affectively. It was represented by over 300 files on my computer, a large A3 notepad and a thick lever arch file. It also consumed much of my waking and dreaming, so that everything I read or watched during that time somehow related to the FNP model.

In early 2019 I began writing up the data for this thesis. During the early stages of the fieldwork, my supervisor had encouraged me to keep my vision on the ‘middle distance’ rather than become overly caught up in trying to make sense of or analyse my experiences. In the initial writing up phase I took up a similar stance, trying to imagine myself inside the data, moving through it, calling to mind triggers and ideas, referencing back to source material and re-reading extracts to illustrate the findings. I tried not to rationalise this process too much for fear of censoring or inhibiting the work, and to utilise my intuitive forces. I was however mindful of ensuring the confidentiality and anonymity of participants, alongside the need to write in a way that was rooted in the data and congruent with my ethical commitments, as described. As the writing process solidified, I started to actively draw on the material I had produced in the data-analytic phase more deliberately. This involved regularly reviewing the secondary data products described above, such as the mind-maps, I poems and the table I had produced relating to the research questions and the nature of relationships. In this way, I used the analytic ‘products’ as a way of checking that the writing was a fair reflection of the findings. I was confident that this provided a robust process due to the range and depth of the methods I had chosen.

Limitations

I wish to end this chapter with some brief reflections on my learning with respect to the study's limitations. Firstly, in retrospect, I regret the small number of one-to-one interviews with clients. I do not mean to imply that interviews with clients where nurses were present are of less value – they were extremely helpful for understanding the relationships between clients and nurses. However, interviews with clients on their own provided particularly rich and revealing data. The FANI method worked much better in this setting, allowing participants to discuss things that it might have felt repetitious to say in front of their nurse. More of these interviews might have yielded even greater insights into the experiences of young parents.

Another potential limitation was using a modified version of psycho-social research methods that did not replicate all of the original features, particularly those which mirror clinical practice in relation to reflection and containment. I did not, for example, have access to a weekly reflective group to assist with processing affective material (Hollway, 2015). Whilst I was able to utilise supervision, reflective writing and personal therapy, I am left wondering whether some of the affective material might have yielded different information had I had the sort of research group which mirrors the infant observational method (Urwin and Sternberg, 2012). I am mindful too of the emotional labour (Hochschild, 1983) involved in this study and wonder about the sustainability of an approach which required privately funded personal therapy. Were I to design this study again, I would consider more carefully the implications of adapting psycho-social methods in this way and how I could incorporate more 'minds'. These reflections, which address my third research question, are picked up in the implications chapter.

Throughout this thesis, I discuss how teenage parents are socially constructed in disempowering ways. The literature presented in the previous chapter points to the dangers of objectifying an already heavily stereotyped group. As later chapters elaborate, my experiences of meeting FNP clients led me to realise the importance of connecting policymakers with those who are subject to their decisions, so that more contextualised, nuanced and humane responses can be advanced. In keeping with this,

I chose a psycho-social frame, underpinned by critical realism and social constructionism because this would allow me to prioritise structural and systemic understandings of social, psychological and interpersonal problems over biographical interpretations. These were ethically orientated choices, in which I hoped to avoid the pathologising nature of some psychoanalytic approaches, whilst offering research subjects generative and emancipatory ways of viewing their experiences. In addition, due to a strong imperative to maintain the confidentiality of participants, very little biographical detail or individual profiling is provided in the chapters which follow. Rather, I have set out clients' voices according to the themes and ideas discussed.

These methodological choices supported the production of research which, in the final chapters, call for more nuanced and contextualised responses to teenage parents. There is irony and regret in acknowledging, therefore, that these well-intentioned and ethically motivated decisions have nevertheless led to a somewhat 'flattened' picture of individual teenage parents in the study, who fail to emerge in as holistic a way as I would have liked. Along with the ethically orientated reasons highlighted above, this was also exacerbated by it being an organisational study, interested in answering organisational, methodological and conceptual questions, rather than focussing, for example, solely on the day to day lived experiences of young parents. As a multi-perspectival study, I sought to give dual attention to the experiences of young parents (independently of, and within, FNP) and the complex professional context 'behind the scenes'. Holding this double focus and trying to understand the interplay between the two elements may have led to a loss of definition such that might have been possible had I focussed on one area only.

In addition, I acknowledge that taking a critical real, embedded approach, and spending much more time with professionals than clients, led to my adopting some of the social constructions and norms at play within this area of policy and practice. One example of this is using the contested term 'teenage parent' or 'young parent'. Whilst I hoped to retain a criticality concerning these things, I am aware that doing this nevertheless has a positioning function, which I may not be fully conscious of, in the sense that everyone is influenced by social norms and constructions, even when we

can draw attention to them. This may also account therefore for the ‘flattened’ picture under discussion.

Although the dataset includes a diverse range of individual young parents, whose voices particularly emerged in the construction of ‘I’ poems, I chose not to quote the poems in the narrative account. I felt that the ‘I’ poems were powerful constructions which might move readers and connect them with individual participants in a way that to some extent mirrored the encounters I had in person. However, I resisted including them in the findings due to an unresolved ethical question about who these narrative constructions ‘belonged’ to and whether it would truly serve the research question to include them. I did not want to risk the poems sensationalising any aspect of participants lives, and was very mindful that any data that reveals individual details about clients’ lives should be proportionate and justified in the light of the aims of the research. It seemed better, therefore, to use the learning from them in the narrative, whilst acknowledging here the cost of this in terms of the ‘fullness’ with which young parents speak through the text.

I am left therefore with questions around how an organisational study like this one can more fully include those who use services within the narrative text. Although I set out to design an emancipatory methodology which avoided reducing service users to welfare subjects and further disempowering them in the process, there is clearly still more to be done to advance these aims. Given that, as the literature review indicated, practice based/organisational studies that seek to integrate the views and experiences of those who use services alongside professionals are relatively rare, the limitations described here underline that this is new research terrain, in need of further exploration and experimentation.

Finally, as the next few chapters reveal, one of the most surprising aspects of this study was the (apparent) difference between the ethnographic site studied and the three sites that participated in focus groups. It is impossible therefore not to wonder how this study would have evolved had I been embedded within another site. It is entirely possible that some of the differences in the material reflect the length of time I spent

with them, but it is also possible that I would have learnt different things about the FNP model. This is an inevitable consequence of the methodological choices I made, but one it is impossible not to wonder about.

Conclusion

This is a multi-layered project, cutting across several disciplinary fields. To reflect this, and do justice to its complexity, I have developed an integrative methodology, which draws on several theoretical ‘lenses’ to produce a rich data set and ‘thick’ description (Geertz, 1973) of the FNP model. I have made the case for a multi-dimensional and eclectic theoretical base, which utilises a range of perspectives and approaches to facilitate analytical thinking across diverse system levels. I am confident that my methodology has supported the production of new knowledge about both the FNP model and the value of psycho-social research methods for learning about complex organisations within the human services, the implications of which I will expand upon in Chapter eight.

Developing new ways of considering the FNP model has been an intellectually and psychically expansive experience. ‘Being psycho-social’ involved holding diverse and eclectic perspectives in the light of an emerging ‘whole’. It involved a ‘use of self’ in which my reflections and responses to the fieldwork expanded and informed the knowledge building process. Engaging in this process was stretching and at times dizzying, as I tried to create new links, connections and conceptualisations of the FNP model in context. Sometimes my mind ached from the effort of ‘digging’ and ‘scaling’ and back again. I found methodological companions in surprising places, like in this description of *Middlemarch* by George Eliot, which describes it as a:

Large-scale social anatomy novel, whose main features are a panoramic seep, from the rich and patrician to the poor and obscure, a set of interwoven plots which connect a variety of socially diverse figures, a keen interest in the subtleties and shifting balances of class relations, a concern with social history, especially the collision between forces of change and of conservatism, and an omniscient narration which combines a critically evaluative overview with intensive focus on selected individual lives (Roberts, 2000)

The efforts of working in this way were immensely rewarding, taking me into new territory where the 'general' and the 'particular' might communicate in generative ways with each other.

Throughout this process, I have also been mindful of an ethical imperative to 'do justice' to the generosity shown to me by participants who shared, not just their experiences of FNP, but also some of their personal stories with me (McNamara, 2009). I have been mindful of the trust placed in me by the FNP NU leadership, amazed by their willingness to subject themselves to 'beneath the surface' enquiry at my hands and inspired by their commitment to learning with me, even if this learning has not always been easy or comfortable. Indeed, across the FNP system, the welcome extended to me and the research process has mirrored elements of the family-nurse data in terms of reflexivity, humility, kindness and respect. I do not take this for granted, or the privilege of being funded, supported and given extensive intellectual freedom by an eager epistemic community who are keen to hear, respond and apply my findings. The ethical complexities that this has given rise to have, in the end, enriched the process by adding to its integrity through the need to resist 'othering', blaming and splitting, drawing me back to thinking psycho-socially and systemically about how certain situations and phenomenon arise. This doctoral research, whilst meeting its core aim of producing new knowledge about the FNP model, has also provided me – and I hope the collaboration partnership – with an opportunity for rich personal, professional, psychic and intellectual growth.

Chapter 4: FNP client perspectives on the FNP model⁶

Introduction

This research is concerned with how the FNP model is operationalised and experienced at diverse system levels. In contrast to most empirical organisational studies of welfare practice to date, this study has taken a whole system approach to data gathering, including both professionals and clients as equal participants. In line with the ethical ideals of the FNP model, it attempts to redress the inequalities of power within welfare systems (Fraser, 2013) by taking seriously the views of FNP clients. It is therefore congruent to begin the presentation of the findings with a chapter on the views and perspectives of FNP clients.

The findings presented here draw on data from two sites: ethnographic observations and interviews conducted in one site and two focus groups conducted in another (Focus Group 1 and Focus Group 2). Participants were in the main young mothers, with a small number of young fathers and grandmothers taking part. In addition, in as much as they seek to portray the views and perspectives of clients, I have included some data from family nurses.

⁶ *I have worked hard to ensure that clients, professionals and teams are not identifiable within these chapters. This was part of my confidentiality agreement with participants and an important part of my methodology. A psycho-social approach pre-supposes that there will be 'messy' material, problems and unresolved issues. Whilst these are treated as systemic rather than personal issues, there is always the danger that were they to be identified, individuals might feel, or indeed be criticised by others. I have tried to avoid this by anonymising teams and individuals throughout these chapters. I have used a single initial to denote a different speaker, with a brief explanatory key where this is necessary for ease of comprehension. Where this is not necessary, I have used the initial 'R' for interview respondent and 'P' for focus group participant in line with transcribing convention. For quotations of my own speech I used the letter 'I' for interviewer.*

I begin the chapter by contextualising the lives of FNP clients. This is followed by a description of how clients experience the FNP model. The writing is structured in line with those issues which were most prominent within the analytic process (see Chapter 3).

The context of clients' lives

I have previously referred to the socially constructed nature of 'teenage parenthood' (Arai, 2009) and summarised the arguments for targeting discriminatory societal structures (Duncan *et al.*, 2010), rather than individual young parents. Efforts to reduce teenage pregnancy are critiqued for appearing to rework the moral zeal of the past, that sought to prevent sexual promiscuity amongst the so-called 'undeserving poor' (Gans, 1995). Within this critical framework, social policy is regarded as perpetuating the sense of shame and stigma that today's teenage parents experience (SmithBattle, 2013).

To begin with therefore, I consider how the study data speaks to the idea of the 'problem' of being a teenage parent. FNP clients' views about what it means to be a 'young' parent are presented, including their experiences of stigma and discrimination. It is an ethical choice to begin with the context in which young parents live their lives. This is to avoid replicating an essentialist approach, wherein clients are viewed instrumentally through the prism of their FNP experiences only. Nevertheless, as I discuss in the previous chapter, the organisational focus of this study and the methodological choices I made impact the nature of the material presented here. It means that whilst I have tried to foreground the voices and experiences of client participants, they more or less remain in the position of 'client' and are seen through this lens, just as family nurses and professionals are considered in relation to their roles. This section presents their experiences, therefore, whilst acknowledging that this constitutes a narrow aspect of all there might be to say about each person who took part. It seems trite and obvious, but still important, to say that each participant's life was much broader, deeper and more nuanced than I have captured here. I acknowledge again the inadequacy and ethically compromising frame of 'teenage' and

‘young’ parent. Taking a critically real approach involved working within current social structures, whilst still being able to highlight how, for example, the term ‘teenage parent’ negatively constructs people who have children at a younger age than the general population. With that in mind, the next section presents some of the social injustices experienced by client participants, before going on to focus on their experiences of FNP. In doing this I recognise however that ‘social injustice’ provides a partial and mediated frame through which to encounter the experiences of the young parents who took part in this study, and in general.

The perceptions of others

I have limited personal experience of teenage parenthood. However, two experiences are relevant by way of introduction. The first is as a teenager, I recall my mother waking me up one morning to tell me some news. In a hushed voice, which carried shock and shame, she told me that the daughter of a family friend was going to have a baby, aged 17. It must have carried considerable feeling because although it was nearly 30 years ago, I have a strong image of the scene. In particular, I remember a kind of paralysis, because I didn’t know how I should respond.

The experience second is much more recent. Just before I began this study, in conversation with a staff member on a trip with my daughter’s school, I told her that I was starting research with teenage parents. Again, I have a strong visual and emotional memory of the moment when she responded by rolling her eyes. “*Those teenagers*”, her eyes implied “the ones that get themselves pregnant”. I hadn’t met any teenage parents at that time, but I felt hot and indignant on their behalf, but also, again, paralysed as to how to respond.

These are minimal encounters, but they underline how teenage parenthood is positioned as unquestioningly problematic within Western culture. The literature, as I have set out, confirms this and yet I was still taken aback by the consistency and nature of the narratives of disrespect and dismissal experienced by FNP clients within the data.

The mothers in Focus Group 1, for example, described how judgement came from being observed by a nameless public audience. In the following extract, the mothers in the groups describe their feelings about using public transport:

- I: You were nodding as well, J, when we were talking about that feeling of people judging you. Is that something you've experienced?
- P1: Not by my family, just by other people, it's the way they look at you. They just think, "She's young, she's got a baby."
- P2: Especially when you're on the bus with a pram.
- P3: I was just going to say that.
- P2: I got on the bus and it was the first time ever I think she [family nurse] was with me. She made me do it on my own so that I would get used to it and people were just looking at me like I'm stupid. I was like, "This is ridiculous," and I just gave the baby to her and I was like, "You do it."
- P4: I can relate to that.
- P2: It's little things like that, that people just look at me like I'm being stupid but really and truly it's like you're just learning.
- I: There is nothing like that moment where you've just completely forgotten how to collapse your buggy when you've got everybody watching, "I can't do it."
- P: The pressure of everyone watching.

The hostility and denigration that these young parents feel are experienced through their sense of the gaze of strangers, which communicates judgement. Participants in Focus Group 2 reported similar experiences, talking similarly about having "looks" from other people. This meant that they avoided going to the local children's centre or going out generally, because of worries about what other people would think of them and a sense that others thought that they are not good mothers. When talking about her experiences of going to a health clinic, one participant said, "you feel eyes on you constantly, thinking - she shouldn't have a baby this young", suggesting that this sense of hostile surveillance creates a sense of isolation and paranoia.

Public experiences of feeling looked down on were spoken about by FNP clients as if they were an everyday part of life, rather than one-off events. There was a ubiquitous sense of the community around them being unkind and unforgiving. Conversely, clients said they valued family nurses for *not* looking down on them, for being kind and

providing space in which they could learn without being told what to do. In this way, an understanding of the hostile context around young parents throws into relief the significance of the family-nurse relationship, who contrasts starkly with the rest of the community in her lack of judgement. Although having a family nurse with her does not prevent 'P2' (above) from feeling like everyone is "looking at me like I'm stupid", it does seem to give her agency to find a solution to her problem. By instructing her nurse to hold her baby, while she concentrates on opening the buggy, she invites her family nurse into the moment in a very concrete way, whilst also demonstrating her own efficacy.

As well as the perception of judgement, participants also shared experiences of discrimination from members of the public and staff in various roles. A young father, with considerable caring responsibilities, talked, for example, about how the teachers at his college expected more of him because he is a father:

R: They have quite a non-judgment thing but I think, sometimes, they tend to take me, as a teenage father and then, because I'm then a father, they will take it that I'm supposed to be an adult and supposed to act more mature. They forget that I'm also a nineteen-year-old. So, when I do things that nineteen-year-olds do, like the occasional disorganisation or not always focusing in lessons, the judgement on me is a lot heavier than on other people.

I: **Really?**

R: Yes, because they're just nineteen-year-olds and they have the ability to fuck up in life but they look at me and think, "But you're an adult now."

I: **But you're the one up at three in the morning with the baby. It's unfair, isn't it?**

R: Yes, they do understand that and they'll make jokes about how tired I am sometimes but at the same time, they're like ... Because it's a situation that I don't think a huge amount of people can understand unless there's been quite a lot of exposure to a teenage parent. The situation is so incredibly different and the majority of my teachers have had children so they understand it to some extent but it is so hugely different when you're a nineteen year old and you have so much to work on. I don't think they take into consideration the nineteen-year-oldness with it. Yes, that's not even taken into

account, the fact that I'm looking after P [partner] a lot of the time. It's a really hard thing and I don't blame anyone for it because if they haven't seen it and have the ability to understand it, they might understand it but it does get frustrating.

This quotation, and the one above it, show how teenage parents experience high levels of expectation from the adult world – to get it right the first time, to be more than an 'ordinary' nineteen-year-old. The young father above attributes this to a confused sense of over-identification on the part of his teachers – perhaps, he thinks, they see him as one of them, but at the same time, they know he is not. In both the extracts, FNP clients feel as if they stand out, and that the adult world is unable to relate to the very particular challenges involved with being both a parent and a teenager. The 'teasing' teachers although they appear benign, may indicate an underlying discomfort with how teenage parents occupy a liminal both/and space which cuts across, transgresses and defies received categorisations of child/adult – an idea which is developed further within the discussion.

Along with implied and tacit experiences of hostility, there were also examples of openly hostile behaviours towards teenage parents within the data. In the extract below, taken from an interview, an FNP client describes a scene in which she is sixteen and pregnant, looking after five children – two nieces, a nephew and the children of a friend. She presents her youth travel card to the bus driver who challenges her rudely, saying that it can't be the right card because she has five children with her:

"Like get the fuck off my bus." He called the police and everything. Then I had to show him my birth certificate and everything, my red book from the hospital. It's like a pink-ish book ...my maternity book. Then they were like, "No, this is not you. You're a liar." I was like, "I haven't got anything to lie about. I haven't got anything to lose. Why am I going to lie?" Then my sister came, the police came and they were like, "It's her." They were like, "I'm not letting her on the bus." Even to this day now I don't get on his bus. They're so rude.

It is hard for me to imagine the stress experienced by this client who, whilst being pregnant and looking after five young children, is violently verbally abused and made

to wait in shame for the police to come to verify whether she is travelling with a legitimate travel card – a difference in price of about £1.50. I am struck by her comment that she “hasn’t got anything to lose”. I sense that she is talking about how she has given up trying to comply with socially or culturally constructed ideas of ‘acceptable’ behaviour, because of experiences like this one, where she is so disempowered. Her cultural and social capital (Bourdieu, 1990) is clearly much diminished, so much so that she is not believed by those with power in this situation. As a highly visible child-mother, something about what she represents provokes extreme animosity. It is not possible for her to be seen either as a ‘legitimate’ youth or respected as an adult, and trying to carry elements of both, she faces social punishment, interrogation and humiliation.

Discrimination by professionals

The consequences of these experiences for teenage parents are obviously significant, affecting their sense of selves and the choices they have in the wider world. In the ethnographic data, there was another strand to this theme in relation to reports by family nurses about their clients’ experiences. These accounts centred on the ways in which teenage parents are perceived and treated by health and welfare professionals. A nurse spoke, for example, about a time when a client was discussing her recent miscarriage within a professionals meeting. One of the workers said that this had “probably being for the best”, adding the client would struggle to look after two children. Whilst responding to news of a miscarriage often causes social awkwardness, this nevertheless seems a particularly assumptive response and lacking in empathy from a welfare professional. Certainly, the family nurse who reported it to me was shocked and upset on behalf of her client.

However, in policy terms – including within FNP – this worker’s views were not controversial. Second pregnancies for teenage parents are actively discouraged. It is possible that it was the sharing of this view so bluntly with the family nurse was upset by, not necessarily the view itself. This highlights the multi-layered discrimination that teenage parents face when even those who advocate for them such as family nurses, may also harbour views – in line with received policy - that their actions are unwise or

questionable. It also points to the complex ethical terrain that family nurses tread, in which they are sometimes called upon to act in one way and think another – a matter I will return to in later chapters.

Several FNP clients spoke about how their family nurse contrasted with another less caring, less sympathetic worker. I observed how family nurses often advocated for clients to be taken seriously by other professionals. One, by no means isolated example, was a mother diagnosed with postnatal depression presenting to her GP with additional symptoms and being told that it was probably just tiredness. She was later diagnosed with a very rare medical condition after A&E attendance. It was her family nurse's view that her client's mental health difficulties, homelessness and pregnancy had coloured the GP's view, meaning that she did not take the client seriously until she was extremely ill. Although it is not uncommon in social work to hear about service users struggling to get their medical problems taken seriously, the prevalence of this strand in the data was notable, with every family nurse from the ethnographic site providing examples of how clients were overlooked or dismissed. They were firmly of the belief that teenage parents struggle to be heard with regards their health needs and recognised their own role in lending clients social, cultural and professional capital (Bourdieu, 1990) to enable them to access the services they needed.

Gender discrimination

Within the younger parenting population, the responsibility for caring for babies falls disproportionately on mothers as compared to the wider parenting population where there is a greater degree of gender balance (Thomson *et al.*, 2011). This 'status quo' was reinforced by the structure of the services – as one of family nurse noted, it was very rare to see a father mentioned on the 'booking in' notes for mothers. I observed that there seemed to be an all-pervading, seemingly hard to critique assumption that the main share of the child-rearing work will be with the mother. She is the client, and the responsibility for 'change' inherent in the programme is phenomenologically, if not ideologically with her because she is, largely, the main recipient of the programme.

In response to research about the systemic way in which fathers are often ignored by welfare professionals (Gupta and Featherstone, 2016), there has been an attempt in recent years to acknowledge the importance of fathers. However, within the ethnographic data set for this study, mothers as sole clients far outweighed situations where there was an involved father who was in any way 'part of' the programme. This is not to say that nurses did not encourage involvement with fathers – they certainly did, and within the course of the study I encountered several fathers, whose views are included here. However, there was a sense that in engaging fathers, nurses were acting counter-culturally, and there was only so much of this that they could sustain at an individual level. This is a culture which includes everything from the timings of appointments and the structure of recording systems, to familial, cultural and social expectations. As such, it seemed to be accepted and normalised that having a child affects young mothers much more than it does fathers.

This gender inequality was an important, all-pervading, feature in the data. In one case for example, an FNP client was believed by her family nurse and her mother to be experiencing domestic violence from her male partner. It was strongly suspected that her denial was due to her complete financial dependence on him, and her unwillingness to return to being homeless with a young baby, as she had been during pregnancy when they had separated. My reflective notes about this situation centred around my feelings of anger about how was it possible for a young woman, not even yet an adult, to be caught within such an 'old fashioned' trap of gendered financial bondage, despite all the advances of feminism? I was also aware of how this unfairness seemed to be largely unnoticed or unacknowledged, and was as such apparently beyond conscious awareness and therefore challenge, by either FNP clients or nurses.

Teenage parenthood as a proxy

The FNP model is predicated on the premise that teenage pregnancy is a proxy for multiple vulnerabilities. One FNP client, when talking about the complexity of his situation, and how few people understand, said: "I find that hard to get into words - the amount that I have going on". His experiences had taught him that teenage

pregnancy is often a visible symptom of hidden and complex disadvantage or social need. In order, therefore, to contextualise the lives of FNP clients, I will present here the data relating to their wider social experiences, as a way of bearing ethical witness to the injustices I observed. This section will focus on two of the main issues prevalent in the data, namely mental health and housing.

Mental Health

Being affected by mental health difficulties was extremely common for the young parents who were part of this study – far greater than the often quoted one in four within the wider population. For a few, like in the quote from the father above, this was a pre-existing issue, which he considered to be a large contributing factor to the pregnancy coming about. For others, the effects were felt through being a close family member of someone with mental health difficulties, for example, the client whose mother's long-standing depression had led to her having caring responsibilities for her three siblings for most of her childhood. The most common scenario, however, was for formal mental health diagnoses to begin with postnatal depression, sometimes leading to prescribed medication. Often however, the life circumstances of clients were such that they would challenge most people not feel overwhelmed. For example, the client caring for her new-born baby in a shared studio-bedsit, having newly arrived in the UK, embroiled in an abusive relationship with a partner exercising long-arm control via the internet. It is not surprising that, in similar circumstances, another client described crying to her family nurse that she felt her baby would be better off with another family.

A small number of participants in the study had accessed mental health support beyond medication. In one rare example, the family nurse and mental health specialist had worked together to provide what sounded like a partnership of support, leading to the client's recovery. In most situations, however, it seemed that accessing psychological support or indeed anything beyond the GP was extremely challenging – the effects of which I will explore in the next two chapters in relation to the professional system surrounding local FNP teams. For clients, a lack of adequate services created and added to a sense of uncertainty and stress, which, although it

might have been mitigated by the presence of a supportive family nurse, was by no means eradicated by it.

Housing

It is, of course, impossible to separate 'issues' as if they are discrete entities having isolated effects on people's lives. Very often, as in the brief examples provided above, mental health issues were exacerbated by inadequate and insecure housing. For some clients, their pregnancy was the catalyst for housing insecurity, particularly those who were in local authority supported accommodation, because of narrow rules around who could live there (i.e. not a baby, or only one baby under a certain age etc.). Other systemic issues included a rule whereby a looked-after child is not eligible to apply for permanent housing in an out-of-borough placement area, even if she is no longer in a placement there and has built a local support network. A family nurse explained this to me following a home visit to a client in such circumstances. Despite having lived in the area with her now two-year old for several years, she was only eligible to apply for permanent accommodation in her original borough of residence, meaning that to stay with her support network, which included her family nurse and foster mother, she must remain in insecure temporary accommodation. For clients living in temporary accommodation, it was not unusual to observe discussions between them and their family nurses about an imminent eviction (within the next few weeks) in which the circumstances of the move – the where and when – were as yet unknown. Clients often seemed resigned, as if these matters were beyond their control, but it was not hard to imagine the underlying stress and practical consequences that such uncertainty must have created, particularly in the context of caring for a young baby.

For clients who were living at home with their parents, the housing issues were less hand-to-mouth, but nonetheless stressful, impacting relationships and their ability to develop a sense of parental autonomy and authority and, of course, causing overcrowding. Several clients had an 'official' temporary accommodation that they felt unable to live in due its poor quality or distance from their family network, but which they had been told they should apply for as the first step towards gaining permanent accommodation. In such circumstances, there might be a landlord who apparently did

not mind if the client lived there or not, as long as the rent was paid. In this way, clients were inducted into 'working the system' so that they could gain a suitable place to live independently with their child. In another example, an FNP client admitted that she had been instructed by her social worker to lie to her family nurse about a possible move of accommodation, due to a fear that this information might jeopardise her availability for FNP services. In this way, the data reveals the multi-layered personal cost of housing insecurity for clients, involving a practical, social, emotional, ethical and moral challenges.

Although family nurses and clients agreed that this was not ideal, there was no sense that they might have a role in changing or challenging such a system. In fact, like gender, the scarcity of good accommodation and an individualised rather than systemic response was normalised. Family nurses sometimes criticised clients privately for their lacking gratitude for above average accommodation, rather than considering that clients, like anyone else, are allowed high expectations regarding where they would like to live. Nobody seemed to think it problematic that a person should be considered "lucky" for having their basic need for decent accommodation met in the first place.

Complex injustice and challenge

There were, of course, many other themes of social inequality, disadvantage, discrimination, oppression and injustice present in the lives of the FNP client. Clients were affected by multi-generational involvement with safeguarding services and both criminal and sexual exploitation emanating from outside and inside their family situations. Some clients reflected on the shock and emotional turmoil which accompanied their first few months of pregnancy when they tried to come to terms with an unexpected life trajectory which carried a strong sense of failure. One client's mother did not speak to her for months when she told her that she was pregnant. As described, young parents were affected by multiple judgements, health inequalities, economic poverty, inadequate welfare services, and, in a few cases, a profound lack of family support. These sat on top of the 'ordinary' vulnerabilities that come with being a first-time parent, as well as the 'ordinary' complex adolescent feelings that veer from

ecstasy to despair (Pombeni *et al.*, 1990). Together, these contributed to a picture of FNP clients with profound and significant challenges.

During my fieldwork, I wondered about how participants had survived these challenges, which must have required such strength and resilience. I often shuddered to think how I would have coped in similar circumstances. In keeping with the literature about teenage parenthood however, I also found exceptions – clients for whom being a parent had not been unwelcome or a shock, or who were well supported at home. It is important therefore also to say that whilst, on the whole, this data paints a grave picture, this is not the same as claiming that teenage parenthood is inherently problematic. As I have repeatedly argued, the challenges were not associated with clients' personal failings, but rather a hostile and discriminatory context. Having set this scene, I will now turn to clients' views and perspectives on the FNP model.

What happens in home visits

In this section I will set out clients' experiences of 'having a family nurse'. The headings are structured according to those elements which featured prominently or struck me as significant during the analytical process described in Chapter 3.

Asking my family nurse questions

At the heart of the FNP model is the idea that family nurses do not give advice, but support and facilitate clients to discover answers for themselves. Despite this, participants consistently spoke about the value they placed on being able to ask their nurse questions. I observed this on very many occasions during home visits, where it would seem as if clients had 'stored up' questions for their family nurse. These ranged from health related issues, e.g. "is my baby's head the right shape? My GP says it isn't"; issues about accessing services, e.g. "how do I get a nursery place? It's very confusing and they all seem full"; to requests for information and discussion, e.g. "What, exactly, happens in labour?".

The availability of nurses to answer clients' questions was not limited to home visits - a family nurse showed me a WhatsApp message from a client which had a picture of her baby's stools and the question – "Is this normal, should I go to the GP?". Similarly, a participant in one of the focus groups spoke about how she regularly texted her nurse when she had questions or concerns. Participants did not say that they valued getting *answers* to their questions, although in all of the above cases I observed family nurses listening and responding, sharing their knowledge and information to what seemed to be the satisfaction of their clients. Their emphasis was on the freedom they had to *ask*. In the extract below from an interview with a former FNP client (R1) and her family nurse (R2), they reflect together on this aspect of their relationship:

- R1: Yeah. No, I always enjoyed [family nurse's] visits because I didn't really have anyone come and visit me or anything, and it was nice to talk to someone, even if it was just like, I had a little rant, didn't I?
- R2: Yeah, yeah, that's alright. I didn't mind that.
- I: **Yeah, someone that you could talk about all the difficult stuff with.**
- R1: Yeah. And ask stuff as well. I didn't know what I was doing, do you know what I mean?
- I: **Yeah, yeah.**
- R1: Like, I had my brothers, but I was aged 5 when they were born, so I didn't remember much of them being babies.
- I: **No.**
- R1: And I don't have any family with young kids. Well I do, but I don't see them much. So, I didn't know what I was doing, and I did have to ask some stuff.
- I: **Can you remember what kind of stuff you asked?**
- R1: I asked them what babies' milk to get, I remember that, and nappies.
- I: **Yeah, yeah. Because there are such a lot of different choices, aren't there?**
- R1: And it is hard. And like, when to start weaning them and everything, and all that stuff. Because you don't get told what's the best. And if you ask for anything in hospital, all the nurses are just like, "Oh, you have to get it," and all stuff like that. They're not very helpful.

This extract highlights the contextual nature of why asking questions is important to FNP clients who feel dismissed and judged by many professionals. In contrast, her family nurse is available and listens to her – she even lets her have "little rants".

Talking about how she identified her now favourite brand of baby milk, she recalls a process, whereby her nurse helped her to think and make a choice. Like other clients in the research, she felt safe to ask questions, even though this might have risked revealing what she does not know and inviting criticism.

Within an environment where young parents feel highly judged, asking health professionals candid questions, open clients up to their judgement. Tolerating the vulnerability of 'not knowing' sufficiently to be able to share this with someone who has considerable professional power, is, to say the least, brave. We see too in the extract the way that the risk is worth taking because it brings good things - helpful new knowledge and learning. Helping a client choose her nappies may not be the sort of thing that makes the FNP PR campaign. However, I observed how family-nurse relationships are built on the foundation of these 'ordinary', everyday exchanges, which - although they may well develop openness and trust and leading to deeper conversations – are also highly valued *in and of themselves*. This is one way in which I hope to close the gap between the sometimes grand language of policy and the lived experiences of clients - foregrounding the latter to re-formulate the former, as I seek to do further on in this thesis.

Focus on the child

It was quite a challenge in the fieldwork to get a sense of the responses of babies and children who are part of the family nurse programme. Focus groups and interviews were designed to elicit the views of adult clients, although children were very much present and made their own interventions - as described in Chapter 3. Participants spoke, however, about the interaction between their child and their family nurse, which I also observed this during home visits. For example, one mother described the impact that her family nurse had on her child as follows:

[Family nurse] has showed me so many ways of interacting with him, like using a ball, and showing him throwing skills and building blocks and things like that, and actually getting down to his level and playing with him, and things like that. But she has been able to demonstrate that to me, and now I have actually picked up those skills.

As well as focused attention as described above, whenever a child was present in a visit, nurses would pay them attention by commenting on their appearance, complimenting them and interacting with them. I noticed nurses trying to maintain a dual focus between the mother/father and child, which made for a dynamic flow of activity within the visit. To explore this further, I present an extended extract from my ethnographic notes of such a moment. For ease of following the narrative, I use the initials J (family nurse), F (mother), R (father) and N-H (child):

J asked if they would like to do a piece of focused work with her now. She took out her folder and said she had something called PIPE and told them what the words stand for. She noticed that N-H was playing with the ball and asked if she found it hard to focus on one thing, was it a bit like that at home? F and R were reluctant to enter into this sort of reflection. J pressed on and suggested that they might want to do something focused with N-H now. She encouraged them to sit on the floor with her and 'show play' with the ball with her. F went down onto the floor and R went the other side of N-H and they each rolled a ball to her. There were two balls and N took each one and held onto them and put them in her mouth. She enjoyed the balls and seemed to enjoy the attention. She reached them out towards F and R but also to myself and to J. J sat back from the scene as if to encourage them to play without her involvement and I tried to deflect my gaze from N-H to F, whenever she looked at me, to encourage her to play with her.

After a few minutes J made suggestions, like it might be easier for N-H if they removed one of the balls so that she could focus on just the one. They did this immediately. She also suggested they could praise her when she 'got it right' and asked them both if they liked being praised. Neither of them really took her up on this invitation to reflect, but they did try to praise her.

After a few more minutes J asked them if they would like some feedback. I sensed she was a bit nervous. She said she was learning with them and seemed unsure whether to read something first which was more about the theory of playing and learning or whether to tell them what she saw. She started the former and then changed to the latter. She said she noticed the way they praised N-H and noticed how receptive she was. She also noticed the way that R had gone to one side of N-H while F had sat closer to the sofa, so that N-H was effectively between them.

J asked if this was a reflection of how things were between them? Was it the case that N-H had to focus on one of them and then the other, but not both of them together? Neither F nor R took this up, but R did stand up and move to sit next to F so that N-H could see them both together without moving her head around. J said, "let's see what happens?".

N-H played with F and R together and J commented that it was easier for her to do that. She then encouraged F to end the game and saying, "it's good to have a beginning, middle and end". She then spoke enthusiastically about how bright N-H is and that if they can help her to focus at home, then when she gets to school, she will be able to learn. She asked them if they understood what she meant – did they find it hard to concentrate at school? F said she had found it hard and for the first time took up a thread briefly and agreed with her about something. F also agreed that N-H is bright and said she could do the actions to "Wind the bobbin" and "The wheels on the bus". She tried to do it with her then, but N-H didn't seem too interested.

I have included this extended extract because there is a danger that only using summaries creates an idealised image of a family nurse, a Mary Poppins figure, picking out toys from her bag and magically cheering up depressed families. In this scenario, the family nurse is 'feeling her way', at times unsure of the reception she will receive. This makes sense in the light of the fact that just before this moment F had been in a very angry state (about a possible eviction) and it was not clear whether she welcomed this change of focus. Indeed, F does not provide her family nurse with much overt 'positive feedback' in response to her quite instrumental interventions to bring about an interaction between the family. The fact that both parents take up her invitation might be to do with their trust in her; or it might be to do with her power as a professional in their lives, who has brought an unknown observer to watch them; or

most likely a mix of all of these. However, the result is that they do seem to take in and own some of her suggestions, and in doing so, for a few minutes, we all make space for N-H and her emotional and developmental needs – she has four minds attending to her.

Alongside these deliberate attempts to focus on a child, other interactions were of the everyday variety – cooing over the baby, getting involved in building with blocks, singing nursery rhymes. Sometimes family nurses would also bring along a baby doll - an FNP tool used by nurses to model interaction between a mother and child. Each nurse has a doll whom she names during initial training. These dolls divided opinion in the focus groups – some clients said they found them embarrassing to have around, while others seemed to find them useful. In my observations, I only saw the doll used once, but in this extract from an interview with a family nurse, we hear her perception of how her clients respond to this aspect of the work:

- R: I think there's a lot of role modelling that we do that's not necessarily with a doll, and a lot of that. We do it with a doll, I'm very aware of making sure it's with a doll a lot of times because you can disempower them with a... you know, if you start doing it with their child, and it's better. But I've had a lot of moments where I've felt clients really staring at me when I'm interacting with their child.
- I: **Oh, right?**
- R: I've had that a lot and I can feel that they don't see that a lot and I think that's a really good thing to be doing.
- I: **They don't see other people interacting with their child?**
- R: No, no, so I've experienced that a lot.
- I: **What does that do, do you think, for people, seeing other people interact, or seeing someone like you interact with their child?**
- R: I just think it might make them feel proud that their child is enjoyed by others. Gosh! I feel emotional!

This nurse describes how powerful it can be for a client when their family nurse shows a particular kind of attention to a family. This is more than modelling a technique – it cannot be done with a doll because it involves an emotional connection, a mutual

feeling of appreciation directed towards a real child. As I have noted and will return to later, many clients spoke very positively about their family nurse. In my initial attempts to make sense of this, I failed to understand the reason for clients' strength of feeling for their nurses: home visits seemed quite mundane, sometimes a bit rushed, sometimes awkward. However, over time, I began to tune-in to something beneath the surface, part of which is thrown into relief by an understanding of the public, professional and sometimes familial contexts of clients' lives, which can be so harsh and unwelcoming. Therefore, whilst teenage parents are at best tolerated and at worst actively looked down upon by many, family nurses, as we see in the extract above, offer a very particular sort of appreciative attention. This is not like any other sort of interaction being offered to them – it is a gaze, a look which, unlike the “looks” of strangers discussed at the start of this chapter, conveys love, admiration, respect and pride – almost like Bion's description of ‘reverie’ between a mother and infant (1962). This is not a ‘magic’ technique; it is an ordinary-extraordinary humanising process - psychological, emotional and social – of validating and acknowledging a mother or father in their parenting role. Understanding this helped me to make sense of the feelings of self-confidence and self-efficacy that clients displayed, and the strength of feeling they expressed about their family nurse.

Weighing and developmental checks

Home-visits varied from observation to observation of course, but one of the most frequent things to happen was the weighing of the baby or child. This was something which was spoken about by clients as being helpful to reassure them of how their baby was, in the words of one client, “getting on”. As a clinically driven, objective measure of a pre-verbal, non-mobile child, weighing holds a great deal of significance at this stage of development (Weaver, 2010). For clients, having their family nurse regularly weigh their baby is something which seemed to relieve their anxiety and gave them confidence. One couple talked about how their son had “always had problems with his weight”. The worry of this meant that they were grateful for the way that their family nurse:

Does the medical checks to see how we are, see how he is. See how he's been eating, whether he's sort of gone forwards or backwards with his eating, is he sleeping?

Their family nurse is a trusted health expert providing them with knowledge and advice, which they then use when dealing with hospital referrals. Whilst weighing relieves anxiety because it is an 'objective' measure of child (and by inference parental) success, it was also valued because it avoided clients having to attend a clinic. For clients, the process offered a chance to avoid stressful public negotiation around the bureaucracies of motherhood (Berry, 2018). This was exemplified in an observation between a family nurse (V) and client (O), as this extract shows:

V asks O - how are things? O says she's doing well. V says it's been a while since she's seen her. O agrees it has, but that she's really glad she's got a family nurse. Pausing, she says "you know, I was talking to my friend who has a baby." V nods.

"So, my friend goes to get her baby weighed and the people there, she doesn't know them, and they tell her that she's doing things wrong with the baby, but they don't even know her or anything, so it's much better having you" she says, looking at V.

Here is another gaze which clients wish to avoid – the harsh clinical environment – described by O's friend, who feels judged and admonished health professionals for being inadequate in her parenting, despite them "not knowing her". This contrasts with the knowledge which family nurses build up over time such that any changes in a baby's development can be thought about in the context of a relationship. Taking this trust further, one of the family nurses in the research chose not to automatically weigh babies during her visits to clients, because of a critical awareness that clients can become reliant on it. Her thoughtful withholding was aimed at promoting a client's internal confidence, being able to see with their own eyes how their baby has grown and trusting in that. Weighing therefore, within the family-nurse relationship is a mechanism heavily laden with affect and in its cultural and social meanings is a key site for negotiating the client's relationships with inside and outside worlds.

Making connections

Another important feature of the family-nurse relationship was how nurses support clients to negotiate their wider networks. Many clients referenced how valuable it was that their family nurse connected them to other services and facilitated new experiences. During observations, I often saw family nurses and clients encourage and support clients to access other services, or in some cases actively brokering contact on their behalf. Nurses were also involved in supporting clients' personal networks and relationships, sometimes both at once – as in the case of a nurse who met with a client's partner's probation officer to support a strengths-based approach towards him. From a psycho-social perspective, nurses seemed to move between what might be thought of as a maternal (nurture and care) role and paternal (encouraging independence and confidence) role, and this was played out especially in the way that they helped clients to negotiate their wider networks.

Connecting with services

I observed and heard about family nurses connecting FNP clients to a range of services, including housing, health (sexual, mental, physical), childcare, safeguarding and career services. Clients valued their family nurse's knowledge, especially when, for many, the wider world beyond their immediate family was largely unknown. Their family nurse was something of a life-line in this respect. I observed how 'signposting' was tailored for clients by their nurses, who worked to increase their chance of access. Below is a vignette from an interview with a client (Z) and her family nurse (G), which reveals some of the subtler meanings of this aspect of the FNP model:

The conversation turned to how G had opened up Z's options for support from other places. Z said it is possible to 'google' things, but G had provided her with information that was more reliable and in a more helpful format. Talking about services, Z used the word 'surface' rather than 'service' by mistake - immediately laughing and correcting herself, but the malapropism became a joke between us. Z talked about how she has learnt when to "bring people to be involved in my life.

And actually, expressing things, and speaking about personal issues”, though she admits that this is still not easy for her. She talks about realising that a mother and baby group she attended was not right for her, through drawing on her intuition (it didn’t “feel right”) and her rational mind (“I felt I had enough going on....I wanted to make the most of one thing at a time”). Later G returns to the language of ‘surface’ and ‘service’ to reflect on and affirm how G has chosen a depth of experience with the few services, rather than to have ‘surface’ experience with many.

This client’s way of managing boundaries contrasts remarkably with her description of herself when she met her family nurse over two years previously, when she was “scared” and “very unwell”, having been diagnosed with postpartum psychosis. Part of the explanation for this change is found in the way that together they have used the process of negotiating her involvement with other services as an opportunity for wider learning. The process has acted as an extended metaphor for the client’s recovery, as she has learnt how to take an active role in choosing what she and her son do or do not need. Very gradually, the family nurse has ‘weaned’ her client from her intense, home-based, tailored support to something more challenging to digest. This process has been very much client-led and mirrors the wider task facing young people at late adolescence in relation to ‘individuation’ (Grotevant and Cooper, 1986). In this, far from being just an embodied catalogue of information about available services - as we saw with the issue of weighing - family nurses can work with this aspect of the model to support clients to separate from adult figures and develop their own adult identity in the world.

Connecting with family members

Alongside supporting connections with welfare service, family nurses supported client’s negotiations with those in their personal networks, in particular their relationship with parental figures. For clients who lived with their parents, this work often involved supporting the development of maternal and paternal identities in the context of complex boundaries, as I saw, for example, during an observation of a family nurse (J)’s visit to a client (T) and her baby (E). This client’s family network and their wider social needs had placed T in a particularly disempowered position, making it difficult for her to take up her maternal authority and exercise agency. She had not,

for example, applied for the independent accommodation she needed, because her mother wanted to apply for a grant to install a carpet in the family home, which she could only do if there was a child under one (baby E) 'officially' living with her. In reality, due to overcrowding T was mostly living with her partner's family, the impact of which is discussed in this extract from my observation notes:

J asked her what she is finding difficult and T said, in a quiet voice, that she just finds it so hard to leave the house. J asked her to talk her through what she does to leave the house and T described her routine. When J suggested that she didn't bath E in the morning but leave it for the evening T said she would like to do that but her 'mother-in-law' says she should do it in the morning. J probed this with her gently and T agreed that there were a few things where she felt differently to her mother-in-law about, in terms of how to bring up E. J gently encouraged T to consider what *she* thinks is best and reminded her in a supportive way that she is E's mother, but she understands that she might feel that her 'mother-in-law' has quite a lot of experience and influence, in her own home.

This FNP client is caught in a limbo state between two homes, neither of which seem conducive to developing her sense of confidence in own mothering. Her family nurse attempts to gently and sensitively bolster her internal sense of 'home' – encouraging her to trust her own mind and feelings, as something she can rely upon. However, the influence of the family nurse, beyond trying to alter her perspective, seems limited, with so many complex economic, cultural, political and social factors determining the space within which the family will grow. The vulnerability which comes from being caught between two homes was echoed by a young father, who said:

We're sharing two houses that aren't our houses. So, we're not able to do things the way that we want to do them because it's the fact that it's our parents' houses or [girlfriend's] parents. I have a sister and she has three sisters, so, there's always people to look out for so we can't just do things our way. Like, do things with the baby that we want to do.

Although a lack of physical space severely affects their familial identity, at another point in the interview from which this extract above is drawn, this client reflects on how his family nurse has helped him and his girlfriend to think about themselves as "an actual family". By taking them seriously and respecting them as a family, she opens

up psychological, affective and imaginative space in which they can develop this identity.

I recognised a similar process in the account given by a family nurse of her visit to a client in hospital, just after she gave birth. Many of the women from the baby's paternal side had come to welcome the baby. The client, who came from a different religious and cultural tradition had not been expecting this. The family nurse described her looking quite lost and overwhelmed by what was expected of her. The nurse arranged for some private space for her client, giving them some brief breathing space without being watched. In a similar way I saw nurses in home visits claim a temporary, physical space for clients to occupy. In these instances, their professional weight allows the family to 'take over' a communal space, the rest of the family receding to the edges quietly. By doing this family nurses create a kind of privacy force-field for the duration of the visit, offering the family a different type of 'home' experience.

To support these processes, family nurses enter into relationships with clients' parents whenever and however they can. Mostly this is focused on building alliances, for example, in the case of suspected domestic violence alluded to before, the family nurse collaborated with the client's mother in an attempt to support the client to disclose what was going on and maintain contact. I interviewed two maternal grandmothers who spoke positively about their daughters' family nurse. One described how since having a family nurse, her daughter had been more open to conversations with her about issues like breastfeeding, which she had avoided before. In this way, she conceived of the family nurse and herself together forming a "safety net" for her daughter. It was a relief to have someone join her in this task, she said, someone with wider knowledge about things like the importance of 'skin-to-skin' contact after birth. Another family nurse spoke about how she worked with a client who involved her sister-in-law, aunties and other family members in her visits. She described how they would all ask her for advice and support with English language translation. "This was real family nursing" she said - proud of the tailored flexible support she had given.

However, sometimes nurses felt grandmothers to be over-intrusive and looked for ways of reducing their influence. This data suggests that FNP may benefit from reflecting on the research on diverse forms of mother-baby attachment practices, including cross-generational mothering, to avoid inadvertently and uncritically reproducing contested Euro or middle-class centric approaches, as highlighted in my literature review. Although overall, family nurses and grandparents were aligned, sometimes family nurses gave advice which contradicted that of a client's family or culture. Common areas of divergence were around discipline (FNP promoting praise rather than punitive approaches) and weaning (FNP promoting the avoidance of solids until 6 months old and processed food altogether). Although I had been given to believe that differences of opinion between family nurses and clients' parents were a prominent feature of the FNP model, participants did not raise this as an issue that was of concern to them. Instead, on the whole, they experienced the relationship between their family nurse and their parents as generally useful for providing a 'third' position within their dynamic, removing some of the intensity and creating the necessary space for transitioning to occur.

FNP Programme Material

One of the most visible aspects of the FNP model is the programme material – which includes a manual of 'facilitators'. These are educational and reflective sheets that nurses give out and work through with clients, to support learning. Each visit within the programme has a corresponding pack of sheets, which have been pre-selected to relate to the family's particular stages of development. Some clients received the facilitators positively, treating the sheets as they might any other sort of educational programme, i.e. filling them in and storing them in a lever arch file, for later reference. The extract below illustrates such a case, where a client close to graduation is reflecting on her collection of sheets, what they contain and how she uses them:

R: I've got a folder somewhere in my house, I think it's in my cupboard there. She does give them to me. This is what we go through. I've got 'how to play with kids', 'how to interact with them', 'turn the TV off when you eat dinner to interact with her', 'play with her', 'fast food', 'toddlers', 'using DVDs', 'how to communicate', 'walking', 'speaking to your child'. We've done this.

She's got this one already, 'me and my child'. 'Role model', 'home safe equipment'. 'Potty training', I did that one a long time ago. 'Moving tips', 'moving checklist'. We've done loads and loads. They're in my folder but I don't know, I haven't checked for ages. I think the last time was when I was weaning [child].

I: So you haven't been putting them in the folder for a little while?

R: No.

I: What do you think of those then? Are they helpful usually?

R: Yes, normally they are. If I'm worried about [child]... I don't know, I thought she had chicken pox one time, so I looked through the folder to see because we were talking about it a couple of months ago. Then it didn't turn out she had chicken pox, she had a rash on her leg and her back.

I: So you can use them to go back and check things?

R: I normally do. If I'm worried about [child]...

Like several others, this client was reassured by the facilitators, finding them to be a source of help when she is worried about things. Later on, I asked her if was going to keep the facilitators and she said, "Now I've left her [family nurse], I wouldn't be able to do anything else with her, so I think I would, yes." This sentiment was also echoed by clients who were coming to the end of their time with their family nurse, whereby the facilitators were invested with the memory of their family nurse. In this way, it seemed that for some clients, the material objects that nurses left behind in their homes became affective symbols, akin to transitional objects (Winnicott, 1971), which supported their ending process. In the extract above for example, we see that even though her child does not have chicken pox, her anxiety is reduced by having the sheet there to consult. Having them also increases her sense of being able to deal with her future problems that might arise.

Other clients spoke more ambivalently about the facilitators, describing them as "patronising" or "childish". One client spoke about it being irritating to be "asked over and over how much we were going to love our baby", preferring conversations that seemed less "scripted". It seemed as if, for such clients, they 'tolerated' the sheets due to how much they appreciated other things about their family nurse. However,

whether clients felt that they benefit or not from facilitators, these were by no means the main thing about FNP appreciated by clients. Rather, the programme material seemed to figure as the 'skeleton' of their FNP experience, in which the 'flesh' was made up of the relationally driven emotional care and support provided by their family nurse.

Emotional support

Clients attached great value to the emotional and psychological support they received from their family nurse. They described their relationships with their family nurse as "supportive", "consistent", "reliable", "safe", "personal" and "close". To several, she felt like a family member. Clients spoke about how much they valued being able to share painful feelings with their nurse, including crying. One client told me about how, amid a lot of "jolly" talk – which he found difficult – his family nurse had asked a simple question about what he and his partner would miss about their life before their baby was born. This had a transformative effect, permitting him to stop "pretending everything is fantastic", leading to other honest conversations with family members about how he both loved his child, and at the same time, found life extremely hard. The following extract from a focus group client typifies these narratives about the nature of the family-nurse relationship:

I am going through quite a difficult time with my depression and anxiety at the moment and she referred me to this healthy mind thing where I'm starting group therapy next week. I would tell them about that, how great a help [family nurse] is towards how I'm feeling. I can open up to her the way I can't open up to my partner because he doesn't understand but when I'm speaking to her she'll give me advice on what to do and how to solve what I'm feeling, stuff like that.

I have repeatedly pointed to the importance of understanding material such as this within the context of the discrimination which young parents experience. The fact that so many clients talk about their family nurse in superlative terms is linked to how the care they receive from them contrasts with what they experience elsewhere. A family-nurse relationship therefore, is a complex psycho-social process in which the negative wider context can, paradoxically, serve to deepen the potential connection between

them. I was continually amazed at the courage of clients in entering these high-stakes relationships of trust with professionals, presumably overcoming considerable defences so that emotionally honest relationships could develop. However, I was also not surprised that – as the next chapter discusses – this was too difficult for some young parents, who declined the service.

In the extract above, the client celebrates the way that her family nurse “gives her advice on what to do”, linking this to the way that her family nurse understands her (unlike her partner) and how she can openly share her feelings with her. On the surface, this poses something of a challenge to the idea that ‘advice giving’ – defined as directing rather than allowing another to find the answer for themselves, is contrary to FNP’s person-centred approach. However, there is no suggestion that the client feels controlled, and indeed elsewhere, she strongly agreed with her peers that her family nurse “never tells her what to do”. My understanding, based on wider observations is that clients value a range of ‘ordinary’ responses from their family nurses, within a relationship of genuine mutual respect and care. What seems to be important to clients is having a ‘good enough’ space in which vulnerable feelings can be expressed, rather than the techniques used to elicit or respond to these. Although nurses may not always ‘sit on their hands’ as they are encouraged to within their training, the data indicates that clients may find such deviation helpful. It was certainly true that nurses sometimes seem to find it hard to tolerate their clients’ suffering. Equally, it is important to remember how a term like ‘advice giving’, which is defined and understood clinically within FNP, also has diverse colloquial meanings ‘on the ground’, making straight-forward interpretations impossible. What can say is that listening closely to the day-to-day narratives of clients about their phenomenological experiences, throws up questions and new ways of thinking about the FNP model.

As I will conceptualise further on in this thesis, the FNP model is characterised by paradoxical features, which can challenge the possibility of holding a ‘both/and’ position or occupying the ‘depressive position’ (Klein, 1935). Depressive position thinking is achieved through containment (Bion, 1970 quoted in Krantz, 2015), which nurses provide when they give emotional support to their clients. This supports clients

to integrate some very opposing feelings, e.g. the joy and pain of parenthood, so that they can, in turn, offer containment to their babies also undergoing extreme feelings of joy and pain. Nurses and clients enter into this terrain, having conversations and sharing feelings, attempting to create spaces where love, care and nurture, joy and kindness sit alongside isolation, fear, inadequacy and despair. I did not often observe 'perfect' examples of attunement between clients and nurses and sometimes I felt that there was considerable 'busyness' in visits, whereby some slowing down and attempting to be more present seemed like it might have been beneficial. However, there is strong evidence from clients that being listened to consistently by someone with a 'good enough' level of care and concern was extremely valuable to them.

Reflecting on 'outcomes'

Taking the micro-level data as a whole, I have considered how clients conceive of the overall 'outcomes' of their involvement with FNP. I present these findings according to the two main areas which came to prominence during the analytic process.

Transitioning

Many clients spoke about or alluded to how they had grown or changed through the process of being with FNP. For some clients not born in the UK, family nurses supported their integration into their local neighbourhood. In one case a creative use of facilitators supported a client's English language development. Speaking more philosophically, a client spoke about how her family nurse had helped her to "find" herself, whilst another said that a family nurse "turns you into an adult".

I have spoken already about the importance of the late adolescent life-stage, which, for most British-born teenagers, is bound up with expectations of an emerging adulthood in which there is a gradual increase of rights and responsibility. Some clients spoke about the tumultuous experience of having their expected trajectory interrupted, vastly altering their relationship with everyone around them and with themselves. As women have children at an older age, and as the numbers of teenage births decline, societal norms and cultural scripts, which might have supported diverse

transitions to adulthood in the past, are greatly reduced (Arai, 2010). Within this context, family nurses support young parents to make sense of who they are and help them to establish a place in the adult world, enabling integration with their past, present and future self-identities. I observed them helping parents to prioritise the needs of their child, whilst also recognising and integrating this with their previous (likely fairly self-orientated) goals. This complex psycho-social process can have many positive benefits, including increased client self-confidence in their mothering or fathering role.

Responsive, emotionally attuned parenting

Some clients came to parenthood with confidence gained through having younger siblings or through studying. As one mother admitted, however, learning at college is different from the reality of actually having a child, and many clients spoke about the positive effect that their involvement with their family nurse had on their relationship with their child. Some spoke about having more confidence in their role as a parent, such as the focus group client who said she had been worried about becoming a mum, but who was happy to tell me – an adult stranger - and a group of her peers who she had not met before, that she feels that she is “doing a good job”. In the following extract a client explains how her family nurse developed her parenting confidence and sensitivity:

R: “I never used to play with him. I used to just let him do it on his own. I know it sounds bad that she helped me gain a proper bond with him, but she's supported it. At first I was just not interested in anything, as bad as it sounds. I just felt, "He's going to play on his own anyway," but she's supported me into us doing puzzles, just doing bricks, the littlest things, playing together, building stuff. Now we will sit there, and we'll build things. We'll play with his cars. We'll do more now than what I was doing. So, I think he'll appreciate that more because he's got a mum to play with now instead of just playing on his own. I'm not all [about] his sister now, I'm more him so whenever she's sleeping we will just make the most of it.

I: **Really?**

R: Yes. It's really nice. As bad as it sounds, he was up about midnight to one o'clock, it was so bad but it was nice

because she was asleep and I had that alone time with [child's name], which I haven't had since I was pregnant with her. It was just nice to just watch the tablet with him. It was nice to cuddle up with him. It was nice to play with him. It was just nice to have that little bond. It was really nice.

This touchingly honest account illuminates some of the mechanisms by which a mother may develop a more responsive approach to her child. It starts with her being open to her family nurse's suggestion to take part in her son's playing. This leads to her feeling more affection and having a closer bond with him. She can imagine life from her son's perspective – she can mentalise his emotional world and she cares about it. Elsewhere in the data a couple explains how they can read their son's communication cues for hunger or tiredness. Another parent described the changes when she shifted her approach from discipline to praise, which included her son spontaneously rubbing her back when she coughed – a sign to her that he was mirroring the gentle, kind approach that she has been trying to follow with him. In this way, we see how the trust within the family-nurse relationships, can be a catalyst for some clients to develop respectful and empathetic relationships with their children and increase their capacity to hold them in mind.

Conclusion

This chapter has described how FNP clients experience the model, what they value about it and why. Although the chapter presents a mostly linear account of how clients responded to specific programme elements, in reality, they often struggled to describe isolated elements of their experience of FNP. When I asked clients to tell me what they did with their nurse and what they talked about, their first response was often to pause, as if a bit puzzled by the question. One client ventured, “everything, really”, reminding me of the sort of answer you might get if you asked someone what their mum was for. I do not mean that family nurses were replacement mothers to clients – although the FNP model calls on nurses to model maternal attachment patterns. Rather I mean to draw attention to how often nurses occupied a sort of taken-for-granted place in the lives of clients, from which it was hard to think about particular things they ‘did’ together or describe isolated qualities. Many clients did not see a

‘family nurse’, but ‘Helen’ or ‘Jo’ or ‘Niah’: a friendly lady, with a particular accent, smell and sense of humour, who is quite scared of my dog but tries her best to be nice to him. She has turned up, got in touch - through text, phone call, WhatsApp, email, even hand delivered letter if all else fails - dozens of times. She has sat in my living room, or on my bed, admired my photos, cooed over my baby, been interested and concerned. She has taken me to appointments, talked to my social workers, spoken up for me in meetings and travelled with me through an incredible period of transformation. Therefore, whilst clients appreciated the practical help that nurses provided and the information that they give them, it is hard to imagine that this would have as much impact if it was not for the existence of the ‘whole’, the embodied along-side relationship, characterised by care and compassion.

I am not trying to say that these were perfect relationships or that there was nothing that clients wanted to change about FNP. Several clients wished, for example, that their family nurse could facilitate supportive peer relationships with other young parents; some clients did not always feel “in the mood” for a visit; and the programme material, as discussed, generated mixed responses. However, the main thing that clients wished for was a way of staying in touch after graduation or to have a way of mitigating the pain of ending their relationship with their nurse through having more flexibility and choice about its timing and pace. The fact that the nurse data – as the next chapter explores – corresponds with this finding is testimony to the strong bonds, built over a long period, that develops between an FNP client and their family nurse.

Chapter 5: The clinical application of the FNP model according to family nurses

Introduction

In this chapter I present the views of family nurses – and to the extent that they undertake a clinical role, supervisors – about the client-facing aspects of the FNP model. The chapter draws on interviews, ethnographic observations and focus group material gathered within two sites, to explore the complexity of the role, which straddles several layers of the organisational ecosystem. Family nurses form intense one-to-one relationships over several years with clients in their home settings, each one with individual and unique features. At the same time, they are involved with, exposed to, and mediate, a range of local and national organisational pressures, expectations and influences. From the client's perspective at least, the role traverses the boundary between professional and personal systems, with some looking on their family nurse as a pseudo family member. Something about the set-up of the relationship leads clients to wonder, for example, why their nurse is “not allowed” (the most common response given), to attend their child's birthday party? They genuinely do not understand.

For many clients, their family nurse *is* FNP: the concept of a team or larger organisation behind her seemingly absent in their minds and experience. Client participants were much more enlivened for example, by questions about their particular family nurse than by general questions about “FNP”, with one client expressing surprise that her family nurse had other clients, besides her. This raises questions about whether the strengths of a highly individualised relational method can inadvertently de-contextualise family nurses. If this is the case, then what are possibilities for family nurses to work collectively and make horizontal, as well as vertical links, within their eco-systems. This is surely important for both clients and nurses, due to the isolation which teenage parents experience and the way that this might be transferred to family nurses through parallel processes (Bloom, 2010).

Whilst family nurses do not reciprocate clients' feelings about being pseudo family members, they do draw on a range of familial tropes and roles. In addition, they care a great deal for and about (Hollway, 2006) their clients – in the words of a clinical supervisor, clients get “inside” nurses. Nurses are drawn to the family nurse role precisely because it offers them the chance of working intensively to integrate their caring instincts and nursing ethics. They see it as their best chance of doing the role they imagined when they first decided on nursing as a career. Alongside this, the FNP model comes with a ‘gold standard’ evidence-base, which promises a longed-for sense of being able to ‘make a difference’. Under the weight of so much expectation, it is perhaps inevitable that the family nurse role sometimes struggles to live up to what it was hoped to be.

In this chapter, I present the data about how family nurses experienced and made sense of their roles. Building on the previous chapter, it adds to a rich description of the FNP model from multiple perspectives. The chapter begins with a discussion of some of the key programme elements that family nurses identified as significant, followed by an exploration of the boundaries, emotional impact and motivations associated with the role. I will draw on the idea that family nurses engage with multiple and complex relationships of accountability, which involve ethical challenges.

Where there are differences between the two sites drawn on in this chapter, I have made this clear, and where there is consensus, the material is combined. To secure anonymity and confidentiality, and to avoid unnecessarily comparison between sites - which could detract from the central ideas – they are not labelled apart from when this is relevant to my argument.

Programme elements

I will begin with family nurses' thoughts and feelings concerning two key elements of the FNP programme's methods. The first is ‘facilitators’ (and other similar material), i.e. the written resources which come as part of the manualised programme and which family nurses take with them to support home visit sessions. The second is

‘graduation’, namely the ending of the family-nurse relationship which happens at the child’s second birthday.

Facilitators and other material

Nurses are provided with a manual of ‘facilitators’ to work with on each visit, as well as several other schemes which are woven into the programme in a more individualised way. One of the interesting findings in relation to this material was the difference between the views of the two sites. Within site A, nurses were convinced by the value of the educational programme and associated material. It was “well-designed” and “trustworthy”, they said. Nurses had “faith” in the material provided, seeing it as a reminder of the “scientific evidence base” behind the FNP model – it was “tried and tested” and it really “worked”. Over time, nurses in site A had adapted their use of the facilitators, as one experienced nurse explained: “at first you think that the material is **the** thing, and then with experience, you revise your opinion”. Another described how knowing the material well enough meant that she was able to adapt things. Another still said that she was now confident enough to realise that “if it’s not facilitating then it’s not a facilitator and you don’t have to just plough through it”. The nurses were aware that the NU was “experimenting” with selecting parts of the programme in response to clients’ needs, and felt that this is how they have evolved naturally in their practice.

Within the same site, there were some contrasting views, like the new family nurse who spoke about how she had been recently taught that the programme material is the “medicine” and that the more vulnerable a client the harder it is to give them their “medicine” because the sessions were “taken up” with sorting out “other things”. This medical analogy, in which young parents are positioned as being ‘ill’ (but not too ill) and in need of ‘treatment’; as well as the idea that clients’ problems are separate from, rather than part of, what the nurse is there to address; seems to be at odds with other aspects of the FNP model which centre on clients as experts and building self-efficacy. It also highlights questions about how relationship-based methods sit alongside a manualised educative programme when the former is fluid, individualised and responsive, whilst the other is more prescribed. Within FNP, the answer to this

conundrum is the idea of 'agenda matching' – a term used to describe the way that nurses are encouraged to work with the motivation of her client to tailor the programme to her best advantage.

There was, however, variation in terms of how confident nurses were at working with this idea, which linked to their confidence in the material and its role in supporting the relational aspects of the programme. Like site A, site B nurses also selected material according to their professional judgement and got to know it over time. Here is one nurse for example, talking enthusiastically about some of her positive experiences of 'PIPE' – a tool which nurses are encouraged to use to supplement the manualised programme:

- R: I've used PIPE a lot and I've got four that I really like and one of them is about attachment.... you have a strip of paper each, two pieces of paper, and you'd concertino them over, like this, but with each one that you do, prior to that you've thought of someone that you, in the past, feel you've had a good relationship with and you look up to. Then, with each fold you talk about why that is. Like, if you've had a good time at the cinema, they always speak to you, they make you laugh, dah, dah, dah, dah. But you end up with this tight network in these two pieces of paper. Then, you get them to pull it apart. I often do my own one with them. You've got to be careful who you choose because you can end up crying yourself. [Laughter].
- I: **Yes, yes.**
- R: So, you pull them apart and they've still got all... no matter how much you pull these pieces of paper, they've got the creases in them and it's showing how all of those shared, positive experiences, no matter how far apart you are, you will always have that connection and that bond and that's what your child is looking for. It's just little... and they all like that. They love that.

Similarly, another nurse spoke about how she had one client for whom the programme was "tailor made". Every time she went to see her, her client would raise a topic and then, lo and behold, the very same topic featured in that visit's facilitator. However, whilst there were positive experiences of using the programme material to engage clients, the nurses in site B were also highly critical of it. One of their problems was the

resistance they felt from clients to the material which led to a sense that they seemed inappropriate or out of touch. In an observation of a visit for example, a nurse pulled out a pack of facilitators, looked through them, pulled a face and said to me “I don’t know who they think this is meant to be for”.

Given this, for some nurses, using the programme material could be quite a risky business, because of their worries that it might come across as infantilising, “cringey”, patronising or even offensive. They also worried that the explorative, playful or reflective tone of the work-sheets was culturally unfamiliar to some clients, more ‘American’ or ‘middle-class’ than they were comfortable with. Clearly, nurses needed to trust the material, but if they could not, they relied on their relationship with the client to overcome this and prevent her from disengaging. One means of managing this was for nurses to effectively ‘apologise’ to clients for the material. By distancing themselves from it, they sought to minimise the possibility that feelings about the material would be associated with feelings about themselves. In the following extract two nurses discuss this issue within a group clinical supervision context (a single letter - not their initial - is used to make it clear when the speaker changes⁷):

M says – but I didn’t expect the material to be so....

L – annoying!

M – well I didn’t expect the girls not to like them...or us not to like them,

L – they can be patronising

M – but sometimes they can work...in amongst a lot of really unhelpful things there is something brilliant.

O, (the clinical supervisor) asks a question about whether it is the material which is a problem, or the context of the clients they are working with....if there are no housing problems and no relationship problems, is the material helpful then?

L - yes, some do say ‘have you got the pack?’...but it just needs cutting right back

O – so you are trained to deliver this programme, but you find you are dealing with things which are nothing to do with the material?

The family nurses agree with this.

⁷ As these notes were written retrospectively following an observation, they are not a verbatim record of speech. They also shift between reported and direct speech.

These nurses express a sense of disappointment at finding out that their clients do not like the material. If clients do not like the material, then nurses may well wonder, do they like me? Do they think I am patronising or annoying? This highlights the delicacy of the relational method used in a home visiting setting and the vulnerability that nurses feel about being accepted and liked by their clients. Nurses felt let down by the material because they felt it left them 'high and dry' in client's homes. It led to existential questions about the model, for example, one nurse asked "if we are not doing the facilitators, what *are* we doing?"

In the context of this uncertainty, the nurses in this site responded in different ways. Some used the reflective space to grapple with their frustration and gain support from their peers. One nurse rarely physically introduced a facilitator into the home visit environment as an object to be worked with. She felt that doing this would be too clumsy, controlling and procedural a way of approaching something which she preferred to see as an art form, and which she approached in a very naturalistic way. Another of her colleagues, in contrast, went the other way and used the designated facilitator in every visit. These differing approaches within and between sites highlight tensions around the extent to which nurses felt they had autonomy and discretion to vary their use of the programme material, the extent to which they could influence its content, and how this related to the FNP model's scientifically proven evidence-base. For some, questioning the material brought the whole FNP concept crashing down: if the material can be varied, what about license fidelity? Ultimately, what is the intervention *for*? These highly relevant questions are taken up in the discussion chapter, later in this thesis.

Endings

Within the FNP model, the intervention ends when the child reaches their second birthday. Leading up to that is a gradual reduction in visit frequency, with the final visit marked with an event and reflective session. Family nurses 'hand over' their client to the local health visiting team, and any other relevant service and have no further contact with their client. Similar to the issue of programme material, there were differences between the two sites around this issue. In site A, nurses had heard that

the NU was considering allowing family nurses to end the programme before the child's second birthday – and they were not in favour. Faithfully following the model in its original form was very important and their experience told them that it was necessary to support the bond between child and parents at a crucial stage in their development. There was, therefore, a view that family nurses should trust the process laid down in the model rather than “fiddling about with it”.

Within the site B, nurses were keen to have the chance to ‘flex’ the graduation part of the programme, in either direction, but were not aware that this was happening elsewhere. Some felt that the rigidity of continuing until a child was two years old, even when a family was “doing really well” sometimes caused them to feel embarrassed at having to ‘chase’ a client who is no longer in need of support. On other occasions, nurses in site B expressed concern about the rigidity of having to cease visiting at two years of age. One nurse raised concerns about damage which might be caused to a child when their family nurse ‘suddenly’ leaves the family at an age when they cannot intellectually process the loss, because although the end is planned and gradual, the subtlety of this might be lost on a two-year-old. These nurses, like clients across the sites, felt incredible loss at the ending of their family-nurse relationships and expressed a wish that there might be alternatives such as, for example, annual contact. The opportunity that my request to interview some graduated clients threw this issue into relief. Observing families and nurses saying goodbye, I saw close at hand the emotional labour (Hochschild, 1983) involved in this process. As we were ending an interview for example, one nurse acknowledged with a heavy sigh that they must “say goodbye all over again”. Another found herself moved to tears when I asked how she felt seeing her former client again, after about a year. Both of these nurses worried whether the emotional closeness between families and nurses might sometimes “do more harm than good” because they built such high expectations of the sort of support that *could* be offered, only for it to be removed just as the family are undergoing another critical developmental transition. Therefore, whilst some nurses seemed content with the way that endings feature within the model, others – on their own behalf and in identification with clients – were critical and less convinced about what they felt was its rigidity.

Personal/professional boundaries

The family nurse role involves a ‘use of self’ that is often emotionally labour intensive, bound up with a strong sense of personal commitment in the context of a high volume of relational work. I grew to understand that within FNP, the navigation of the home/work, personal/professional boundary was complex and laden with affect and meaning for nurses.

Within the previous year, all the nurses in one of the sites had encountered major, and in some cases multiple, difficult life events, such as a bereavement or serious ill health. Most of the team had taken extended periods of sick leave, and discussions centred on the coincidence of these happening to the team during a fairly short time frame. The effects were felt individually by nurses and by the team as a whole: closure to new referrals during a time of lower staffing had, it was felt, led to reduced referral rates for several months after they had reopened. Although nurses did not express the view that the major life events were caused by their work, there was a sense, which was echoed across both sites, of a dynamic interaction between family nursing and home ‘troubles’, whereby nurses’ home lives could deplete their emotional resilience for dealing with the challenges of work and vice versa. One nurse spoke about how she expects her family to understand that she has a “sad job” and that she will not be “bouncing in the door”, while another joked “having a home life – what’s that?!”

Clinical supervision highly valued by nurses for mitigating the difficulties within nurses’ personal lives. One nurse spoke about how it had offered her extended space to process a significant personal loss. However, it was felt that this was small compensation for a role which is extremely demanding, both in terms of the nature and volume of work. Nurses spoke about the “overflowing nature of the workload” and “constant pressure to do more”. Here an extract from another nurse discussing the same theme:

R: Because it does overlap this job, obviously, because it’s emotional and I realise that. This job’s fantastic and you can cope. If you’ve got anything emotional going on... pff!

- I: **Anything at home, you mean?**
 R: Yes. Yes, anything that's like –
 I: **Personal.**
 R: Personal or demanding but anything that affects your emotions. I'm just kind of just saying that, really, it's not easy.
 I: **No, it's because of the intensity?**
 R: Because of the intensity....

This family nurse is highlighting the way that personal and professional emotions permeate and interact with each other. The job is emotional, she admits, but whilst resources such as time and attention can be marshalled according to a rational, conscious decision, feelings are much less malleable and cannot be as readily kept within the boundaries of 'home' and 'work'. There is, therefore an inevitable "overlap" she says, which lives within the body/mind of the family nurse - an overlap between feelings that emanate from the personal and professional parts of her life. When home and life are layered in this way, the boundaries between the two collapse - expressed through the sound "pff!", accompanied by a gesture in which she opened up her hand - a kind of reverse grab - evoking explosion. Her choice of a word that is not a word, which collapses linguistic boundaries through the absence of structuring vowels, powerfully illustrates the uneasy merging that this type of experience involves. She is not saying it is impossible to cope with the emotional toll of the work, but rather that family nurses 'use up' such a large portion of their emotional capacity at work, that anything additional will often prove to be too much for them. The effects of this were seen in somatic illnesses, distress and stress. I also saw unconscious defences being played out, such as internal team splitting and attempts to avoid emotional engagement, such as the nurse who remained silent throughout reflective discussions due to her belief that there was "no point" engaging in what she saw as repetitive, unproductive discussion.

Sometimes nurses struggled to maintain boundaries around their roles. A high volume of cases meant that nurses, for example, regularly took work home to complete in the evenings. This was compounded by the increasing expectations around 'remote working', a euphemism for working from home, brought about by a reduction in available office space and/or the geographical nature of the site. What was striking to

me, was that nurses did not complain, but rather I had the sense that this was taken as the shadow side of doing a job that felt meaningful and important – a cost they had to accept if they were to do a job which “made a difference”. Rather than complaining, nurses managed their responses to the distress and challenges of the role by collectively normalising the high personal cost of the work. Stories of colleagues who had “burnt out” within the wider FNP network hovered like heavy rain clouds on the distant horizon, but this did not translate into a sense that anything needed to be done to change the demands of the role. Rather, family nurses saw the emotional cost of the work as something they needed to take personal and individual responsibility for. They spoke about needing to “be kind to themselves” and within one site, all of the nurses had compressed full-time hours, so that they could have a non-working day during the week. Maintaining boundaries therefore, was an ongoing challenge for nurses, with the emotional implications of the work as the primary exacerbating factor, as I will explore next.

The emotional impact of clinical practice

The emotional challenges of the family nurse role centre on the impact of developing close relationships of care with people who are structurally disadvantaged and experiencing injustice. Within one site, nurses described how being “genuinely alongside somebody” and “sharing your soul”, led to a close affective bond, described by some as “love”. One nurse spoke about how difficult it was being emotionally available for someone when “all [their] hopes and dreams are crumbling down”. At times, she said, it feels as if this is the loss of “my hopes and dreams too”, when “yet another” client experiences her plans “not working out”. Another said that the work could feel “profoundly heavy...you really invest in them, you absorb the hard times, and they are hard for you personally”. She shared her experience of being with a mother who had to “hand over her baby at ten days old” and the pain she felt at witnessing this. Another shared how “you want to do everything for your girls, but it comes at a human cost”.

Nurses spoke about how their experiences mirrored their clients' experiences, with varying degrees of awareness of the psychological processes involved. One particularly reflective nurse described how she feels when she is working with a young parent in the "early baby phase". It is hard, she admitted, to "stay with them visit after visit" through this confused and often lonely phase, and when they emerge from this time – via weaning and crawling – she too feels as if she has "come up for air". This "closing down" which happens to her she explained, which reflected the experiences of her client, meant that there were days when she did not have the emotional capacity to hear the answers to certain questions about how other clients were feeling, and so she would not ask. Therefore, whilst the emotional cost of the work affects nurses' capacity to deal with personal difficulties and vice versa as explored above, it also affects nurses' abilities to work across their caseload.

Other mirroring experiences emanating from the clinical task was seen in the way that nurses spoke about the loneliness and isolation of home visiting, and the way that this made them dependant on their team and supervisor for support – in much the same way as FNP clients spoke about their dependency on their family nurse – a form of parallel processing explored later in this thesis. At other times, nurses invoked humour to reflect on the mirroring of more dynamic emotions, such as anger or frustration: "we behave like teenagers" one nurse confessed, meaning that they 'act out' with one another the behaviour of their clients.

Nurses also spoke about being occasionally treated disrespectfully by clients and how hard this felt. They also spoke about the challenge of holding a person-centred, respectful approach with clients who inevitably, due to their different life stage, have different priorities and perspectives to them. One nurse talked about how she asked herself "how much more of myself do I have to give?" adding, "it makes you flip your lid sometimes". Nurses within both sites grappled with feelings and worries about over-identifying with their clients. They formed close bonds with clients, which they felt very personally. Inevitably, this kind of intensity was hard to sustain for some nurses, with one expressing a wish to return to midwifery where "not every client is vulnerable". Another coping mechanism by one nurse was to split clients into a

‘deserving’ and ‘undeserving’ binary according to whether they seemed either grateful or entitled to her help. Both of these responses seemed to me to be ways of limiting the cost of feeling – which the reflective support structures were not always able to contain.

Unsurprisingly, however, the emotional aspects of the family nurse role are multi-layered. There were indeed difficult feelings generated through having close relationships with people undergoing considerable hardship and suffering. However, family nurses have a particular responsibility within the FNP model to bring about change in the lives of clients, not just to identify with them. The method for doing this involves a complex interweaving of a client’s views and aspirations, the FNP programme’s educational material, and the family nurse’s professional judgement about the client’s best interests. This is a complex enough task. However, effecting change in the lives of those who are subject to multiple structural and systemic inequalities is not straightforward. The contexts in which young parents live and the FNP model operates are also part of the story of the emotional cost felt by family nurses. This goes beyond the idea of vicarious trauma (McCann and Pearlman, 1990 quoted in Reynolds, 2011, p. 28) and is more linked to the interaction of the clinical task with the organisational, societal and cultural context in which it operates. This will be the focus of the next section.

The emotional impact of the systemic and structural context

The emotional cost for nurses of working within a deficit-led, depleted and discriminatory welfare system was present throughout the data. For example, a nurse described how her strengths-based approach had described by colleagues in social care as “colluding” with young people. This, she said, was an oversimplification of a deliberate attempt to treat clients with respect and to “believe in them” – to take them on “face value”, whilst also recognising and understanding the risks and maintaining professional judgement. The FNP model’s emphasis on close and caring relationships between clients and nurses therefore, often seemed incompatible with a wider system so much less responsive to the needs of young parents. Family nurses

often felt the effects of this gap, widened by austerity measures - in one site there were only three, of the original thirteen, children's centres still open. In health, there was a similar situation, with nurses often scrabbling around to find the right service. The feelings that this aroused in family nurses are reflected on in the following interview extract:

It is a programme which is designed to dig deep and I don't know if that's a good idea. Digging deep is great if you've got a fantastic teenage mothers group. You've got mental health on tap that works with teenagers, that understands how to communicate and not just discharge them when they can't get through to them after two calls. Digging deep is great if you've got those services. Sexual health on tap, you know, like... believe me, digging deep is really hard when you've got no services because you end up with it all on your shoulders and I'm learning, but it goes against me, how I am, because I will naturally do that to get to know these people so well.

This nurse is talking about 'learning' to defend herself from what happens when she 'digs deep' into clients lives but finds herself unable to offer an adequate response to what she finds there. This is an understandable response to a situation that feels highly anxiety provoking but also, paradoxically, as she acknowledges, comes at the cost of going against her 'natural' inclination towards building close relationships. The personal burden she feels for meeting her clients' needs might feel more manageable, she suggests, if she knew less about them. This personal burden seemed to form as nurses accumulated embodied knowledge about their clients. The feelings generated from not having services to respond to the needs that nurses had so painstakingly identified included anxiety, guilt, frustration and anger. These were compounded by the generalist and interdisciplinary nature of their FNP role which meant it was sometimes unclear what they were, and were not, responsible for. In the absence of support service to refer a client to, family nurses felt compelled, confused and worried about whether to try to offer something to meet the need themselves.

In one case, a nurse was very worried about a pregnant client with a serious diagnosed mental health disorder, who had been discharged due to non-engagement with the mental health team. Her client had told her that she was only taking her medication

sporadically (something she had not admitted to her GP). Her client's mother had spoken to her privately about her daughter's escalating mood swings, with an expectation that the family nurse could help. The safeguarding supervisor advised the nurse to set up a consultation arrangement with a mental health specialist so that she could provide a kind of in-between mental health monitoring/care service for her client. However, this did little to reduce the nurse's anxieties because this type of consultation was not readily available; the family nurse-as-mental-health-care-monitor was not a formally acknowledged role within the system; and therefore, the nurse felt that she was carrying far too much risk in an area in which she was untrained. Nurses felt that the wider system often left them 'holding the baby' and wishing that others cared as much, or anywhere near as much, as they did about their clients. Speaking about social care colleagues, one nurse asked, "do they know how much we know them?". This feeling added to the isolation felt by family nurses and created a sense of foreboding that if things were to go wrong, they could be held accountable.

The lack of support services was not the only anxiety provoking feature emanating from the meso and macro system levels for family nurses. The same financial imperative, which caused there to be such a reduction in the local infrastructure, also impacted on the family nurses' ability to do their work in other ways. For example, within one site, a unilateral decision was taken by senior management to cease renting the building in which the FNP team were based, under the auspices of saving money. The team was obliged to considerably downsize their office space from three rooms to one (with five people sharing an office which had previously been for two people), in a confusing semi-share/hot-desking arrangement with another team. The change also included an enforced splitting of the clinical staff from their administrative support staff, whom they had worked hard to integrate. This had a significant emotional impact on the team who were obliged to find their own solutions to not having enough space, including keeping equipment in their cars - which took up almost the entirety of their boot, was heavy to move around and was felt by some nurses to be a security risk because scales, for example, might look like something worth stealing. The processes greatly increased the potential for territorialism and rivalry, as well as fragmentation – indeed, within a few months, the supervisor had relocated to an office space in

another building to get some space. In this instance, the financial costs were pitted against other more hidden costs, and these were born individually by nurses who resigned themselves and adjusted as best they could.

The office move example is in keeping with a ubiquitous organisational culture in which there is an expectation that we must 'do more with less', and account for every penny. This played out in the data with nurses being asked to undertake what they viewed as bureaucratic measurement activities, designed to prove the value of their work. The pressure that this placed on nurses was considerable. They talked about trying to avoid its impact "cascading down" to clients, but this took a great deal of energy, as nurses tried to buffer and absorb managerial expectations in a way that minimised the effect on clients. Supporting the production of data was experienced by nurses as being at odds with their commitment to individually determined, qualitative outcomes. They were also keenly aware however that if they did not demonstrate quantifiable outcomes, then decommissioning was, in the words of one, "waved in front of them". The result of this was a mismatch between what nurses felt was important and what they were obliged to demonstrate. Chatting to a nurse as she completed a form which asked her to rate certain aspects of a recent visit, she confessed "I always just put 10 out of 10" - as if to say the measurement held no meaning for her. Another nurse talked about how the possibility of decommissioning might be causing her to disengage from the work to defend herself from what might be to come, thus creating a negative cycle in which paradoxically caring too much had led to her to try to care less.

From a nurse's point of view, burdensome data gathering and recording were seen at best as necessary evils, and at worst oppressive and destructive elements in danger of, in the words of one, "seeping into" their practice. 'Seepage' might involve for example a nurse feeling like she had to "force herself" on a client by insisting on visiting her simply because of the pressure to maintain a good level of 'dosage'⁸, even if this went against her professional judgement that holding back a week or two would be

⁸ The term used to describe the number of visits proscribed by the FNP programme.

preferable. In this instance the nurse's accountability to the FNP licence, the NU and by proxy the wider financial security of the organisation came into conflict with her clinical ethics and commitment to working in a relational and client-centred way, potentially causing persecutory feelings for both client and nurse. Reflecting on the various recording and measuring aspects of her work, one nurse joked that she feels she is a "performing seal". Later she returned to this metaphor saying that she feels "we ask a lot" of clients and that, maybe, in being regularly required to give their feedback they too are being made to perform like seals. Therefore, although nurses spoke repeatedly of a commitment not to pass on the negative aspects of these demands to their clients, this was not always possible. As one nurse remarked, "with everything going on politically, to walk into an appointment with an uncluttered mind and be emotionally available is challenging".

Conflicts experienced by nurses around accountability could, therefore, diminish their capacity for being client-centred. Despite nurses' best efforts to protect them from it, clients were sometimes subject to the same pressures as family nurses in relation to justifying the value of their work to maintain financial security. This meant that along with nurses, clients too were aware of the need to demonstrate 'progress' – their own and their family nurses. As well as sometimes impacting the home visit environment as discussed above, these pressures were also manifest as ethically problematic 'performances' of FNP within public/professional spaces.

An example of this was seen in an observation of an annual review meeting, where a group of parents were invited to meet and address a multi-agency group of professional stakeholders to talk about their experiences of FNP. Whilst I am not questioning the genuineness of the feedback they gave, the intention behind including their voices in the process, or the courage they showed in taking part, I was aware of how they were caught up in the complex process of 'performing' FNP. When clients were asked to talk about their experiences, with their nurse sat nervously next to them, it was both very moving and excruciatingly embarrassing. This painful mix seems to be about the way that complex power dynamics were at play. In some ways, clients were positioned as more powerful than nurses, because they were the ones with the

'authentic' voices being deployed in defence of their nurse. In contrast, nurses seemed vulnerable as they were subject to a public and highly emotive evaluation of their work. In other ways, clients seemed disempowered by this process. For example, although their opinions were sought, the dynamics and rules at play dictated that only positive views were permissible. Added to this was the way that clients' investment in the experience was much higher than professionals. This is seen in the efforts they made with their appearance for the event and in the high levels of personal disclosure (about their mental health, for example) that clients engaged in. I understood this investment to be framed within a narrative of securing the future survival of FNP - and therefore retaining their nurse - the vague threat of decommissioning hovering here too. It left me wondering however, about the cost of this 'performance' in terms of clients' dignity and whose interests were being served by them giving so much of themselves in this way. I also felt protective about the way that clients were being asked to parent within this tense public/private. In this uneasy environment, there was the potential for young children to tune in to this and 'act it out'. Given how judged young parents already are, I reflected on the complex power imbalance in a set-up which could lead to a teenage mother having to deal with a toddler tantrum before a room of be-suited senior professionals. It is not surprising that clients tended to huddle at the edge of the room, leaving a large space between themselves and the professionals mingling around tables.

The scenario seems to exemplify the complex accountability structure and under the surface power dynamics within the implementational context of the FNP model. This came home to me when, at the event, I launched enthusiastically into a conversation about my research with the person sitting next to me, and suggested that, as an FNP stakeholder, she might like to get involved. The expression on her face when she divulged that she was the Trust CEO, followed by her swift departure from the conversation, left me in no doubt that I had transgressed a boundary. I felt mortified – maybe I have known that she was too important to be recruited as a research participant? On reflection, I sense that this was another example of how beneath the surface of this hopeful, idealistic, open event, there were hierarchies, power structures and complex accountability dynamics at play. Here, a CEO might wish – or feel they

have no choice but to - enter into the apparently egalitarian atmosphere set up but then feel insulted if their status is threatened or undermined - and as an observer with a psycho-social sensibility I was tuning in to some of these.

This was thrown into further relief in the second half of the event, which was a formal meeting, once the clients had left. As part of this, a family nurse presented a case-study as a narrative exemplar to the data about the site's performance. The nurse chose to a client who had been at the earlier section of the day, proceeding to name and describe her. She also identified the client's mother because there was a possibility that she might be known professionally to some there – under the auspices of ensuring that the information would be treated confidentially. The nurse then shared with the group graphic details about the traumatic experiences of the client and her mother. My understanding was that she did this in the spirit of highlighting the context of the client's life so that those listening could appreciate how 'far she has come'. The tacit implication, particularly for the commissioners present, was that if FNP can support a dramatic turn-around for young people like this, who have had such traumatic experiences, then it is demonstrably 'a success'. The impact of FNP's value was, of course, increased by the fact that everyone in the room had, a short while before, heard the client publicly explain how much she appreciates FNP and about the good things that have come about for her since she has been meeting with her family nurse.

My reflective notes express feelings of embarrassment and curiosity about how the nurse's evident care and sense of accountability to this client had been subordinated by something equally powerful – perhaps even her sense of survival. I was left wondering why and how her task of demonstrating the value of FNP in this client's life had seemed to demand such a high price – the overriding of important ethical principles such as care for individual clients and the protection of their dignity. This example helps to demonstrate how meso and macro pressures play into the complex web of accountability structures that nurses are subject to, sometimes undermining their accountability at the micro level. It can oblige them to make choices which, ironically sometimes positions the needs of a commissioner – who must be impressed

– over the confidentiality needs of a young mother. I do not wish to take the ‘moral high ground’ here – indeed there are parallels with my situation in terms of being part-funded by the organisation under research, a matter, as my methodology describes, that took some time to untangle. My position, therefore, is one of curiosity about the sometimes murky, moral territory that family nurses – and, as I explore in the next chapter, supervisors – find themselves in. I am interested in the systemic factors that contribute to a reduction in their capacity to foreground the interests of clients and how clinical and organisational factors become oppositional in the first place. There is surely an emotional cost to family nurses of being placed in this position, but this was so defended against within the normalisation of financial accountability processes, that no one else at the meeting seemed to notice that there was anything amiss.

The emotional impact of the pressures discussed above meant that nurses sometimes expressed a sense of despair about the changes that they were able to bring about. Nurses were confident about understanding the lives of clients and joining them, through empathy, in their predicaments. Nevertheless, at times, far from being able to pull parents out of their situations, nurses felt instead that they were pulled into situations in which it felt hard to hold their heads above water. Such was the individual nature of their work that nurses did not talk about working to change the wider system around clients, although they recognised that this was needed. As one nurse expressed “the changes we make are minute because we’re not changing the context” whilst another when asked what one thing they would change about FNP replied “the government”. Both of these are a recognition of the importance of personal, social and cultural systems within which clients live.

Recognising the mismatch between what they had hoped they could achieve through the FNP model, and what they found to be possible in reality was a complex task, to which most nurses in the data had attended. Nurses spoke about needing to narrow the parameters of what was achievable, and that this had led them to find hope within their work, in what one participant described as “strange successes”. I will therefore, turn next to a presentation of the meanings that family nurses attached to their work.

What motivates family nurses

Despite the relatively bleak picture I have painted so far, many nurses were at pains to tell me that they loved their job. This was captured within the phrase “the hardest job I’ve ever loved”, which I understand to be widespread within FNP ‘folklore’ as a way of describing the paradoxical gratification that many nurses towards their role. At the end of the focus group and most interviews, often after the recorder was turned off, family nurses made a point of attempting to redress the ‘negative’ impressions they felt they may have created. This seemed to be linked to a strong sense of loyalty and accountability to the idea and ideal of the FNP model, such that there was a need to restore a good impression that may have been damaged through them sharing with me the difficult aspects of the work. As I explore below, nurses often expressed gratitude for their roles, and perhaps their reparative comments were linked to worries about sounding ungrateful for their good fortune at being allowed to work relationally and with a lower caseload than, say, health visiting colleagues. Perhaps too it indicates a conflation of the FNP model and young parents, as if being negative about FNP and the model is the same as being negative about their clients, whom they care for, and about. Digging further into this, we could also think about this reparative work in Kleinian terms through the lens of a baby’s transition from the ‘paranoid schizoid’ to the ‘depressive position’ stage.

Within this concept, a baby reaches the stage of realising that its mother, who has been experienced as a part objects - classically either a ‘good breast’ or a ‘bad breast’ - is a whole, single person. This leads to guilt and to the baby making reparation for the damage caused by past negative thoughts and feelings, which, it is now realised, were directed towards the good-and-bad mother. Drawing on this theory, it is possible to suppose that the FNP model is held within the minds of family nurses as an idealised mother, whom it is necessary to repair as part of a process of accepting that she contains both ‘good’ and ‘bad’ features. Perhaps this corresponds with FNP’s developmental stage, which involves accepting a more realistic attitude towards its task. Indeed, during a focus group, a family nurse spoke nostalgically about the sort of support that their site used to enjoy from the NU, which was half-jokingly described as “sucking off the NU breast”. She was perhaps referring to the NU’s role in embodying

this ideal mother within the model, and the process of coming to terms with 'her' limitations, which, just as with human development involves growing away from parental idealisation and opens up opportunities for horizontal peer relationships to develop.

As I explore throughout the findings chapters and take up in earnest within the discussion, the FNP model within this context is beset with questions about how it can occupy a both/and, or a 'depressive position', wherein both the 'positives' and 'negatives' can be acknowledged and thought about together. This may well be linked to the complex interplay between the FNP model as nurses first encountered it and their experience of its outworking – which I turn to next.

Relational work – micro level

Most of the nurses in the study spoke about how the FNP model had given them a sense of hope for their working lives. I heard how nurses had gone out of their way to pursue a role with FNP because it offered them a chance to undertake the sort of work they came into nursing for – i.e. a relational, long-term and a structured approach to making a sustained difference. Despite the sometimes isolating effects I have described above, nurses often spoke about the intense relational aspects of the work in positive terms. Just as clients spoke frequently about their family nurse as the only professional, or one of only a very small number of people, who respected and genuinely tried to help them, likewise nurses recognised and drew energy from occupying this 'special' position, especially when they were required to advocate for or defend a client in a context where very few others seemed to care about their welfare. Occasional feedback from clients reinforcing this was a vital source of gratification and sustenance. Cards and messages were pinned onto notice boards and shared within team meetings.

On the other hand, nurses also expressed how the intensity of the challenges and 'messiness' of day-to-day life often meant that it was hard for them to identify and recognise what they were achieving in their work. Unlike in other roles, they could not rely on client feedback as evidence that they were 'making a difference'. As one nurse

explained, the nature of working with vulnerable teenagers meant that this sort of feedback was not always as available:

R: I think I recognised early on, the whole chase rather than the, you know, the client chasing you. In my previous role, I've said this to you before, haven't I, in midwifery health, they're ringing, "Where are you? Blah, blah, blah," which was odd.

I: **Now it's the other way around completely?**

R: Yes, the other way around completely and along the line, I can see that it impacts on the team, that reciprocation that you get in midwifery nursing, you get lots of feedback throughout your day.

I: **Nice little cards....**

R: Or, not even that.

I: **No?**

R: Just being appreciated. You can tell by body language, can't you?

I: **Yes, yes.**

R: Yes, if you rip it all back, that's why we do these jobs. It's a two-way thing. Not a lot of that in FNP and I think that would have been a good thing to talk about in training. That would have been a really good thing, because I think it goes unrecognised and a lot of people might get quite down about that and not quite realise why it is and I think that is it.

This nurse is reflecting on how many people go into 'these jobs' – helping, caring, relational work - to have what she calls a 'two-way thing', a sense that you are helping someone at a personal level. Certainly, there was evidence of this happening, with nurses speaking passionately about the rewards they felt when they had been able to gain the trust of a withdrawn teenage parent. One nurse told me about her excitement when she finally managed to engage her client through a conversation about her budgie, after several weeks of what the nurse felt to be awkward visits where she wondered if the client wanted her there. Data from clients presented in the previous chapter strongly suggests that many greatly appreciated the relationship they have with their family nurse and experience them as bringing multiple benefits into their lives.

However, as the nurse points out in the extract above, this sort of hoped-for reciprocity is often unavailable due to the culture, context and developmental stage of FNP clients. The result of this is that nurses tend to internalise the problem and can get, as she says, “quite down”. This, I suggest, is linked to the structure of the FNP model which prioritises individualised methods, such that its strength - the use of individual one-to-one relationships - can become a weakness. Unintentionally, in the absence a broad range of ways of framing ‘success’ in FNP, the individualistic methods prioritised within the model can lead to FNP clients being *positioned* with responsibility for confirming to nurses the value or success of their work. When this is not forthcoming, for the reasons outlined above, the model does not provide nurses with many alternative ways of reflecting and framing what might be going on – like considering what ‘success’ really means in each situation, or what their feelings tell them about their clients’ experience, the context, or the FNP model. Instead, in the absence of obvious ‘success’ narratives emanating from clients, nurses can feel personally inadequate and experience self-doubt.

Making a difference

Part of the reluctance of family nurses to look beyond themselves for explanations was linked to a strong narrative about the ability of the model to transform the lives of clients. This is embodied in the strap-line ‘changing the world one baby at a time’ which encapsulates the model’s focus on affecting intergenerational change, wherein the child of an FNP parent experiences better life outcomes than its parents. Nurses spoke about how they felt that the outcome ambitions of the programme and the way these had been presented to them had been rather lofty. It is a “glittery” and “dreamy” programme and, alluding to its cultural origins, a “happy, happy, American programme”. Their reflections and feelings about whether the model/they could fulfil its promises varied across sites – a point which is taken up within the next chapter. In one site nurses confessed to questioning whether they were “doing it right” in response to feelings that the hoped-for changes were very difficult to realise. They spoke about how, over time, they had found ways of placing their self-doubts

alongside a realistic view of the way that the familial environments surrounding clients mitigated the hoped-for changes.

As one nurse said, “you’re going in [to families’ homes] for snippets of time, and this is versus whole generations – why would you think you could change that?” For this nurse and others, there was a need to narrow their ambition for the model, in order to reconcile its “glittery” image with what they experienced as a murkier and messier reality. In the other site nurses seemed more at ease with the ideals of the programme and spoke about feeling that they were involved in “changing the cycle of abuse”. They also expressed how gratifying it was to provide someone “who is ready for it” with an opportunity for a different kind of life, in which they can cease to repeat the patterns they inherited from parents.

All nurses however, even those who were less ambivalent about the high ambitions of the programme, preferred small narratives of success focused in on moments, rather than overarching, long-term grand claims about their achievements. They spoke about how they had learnt to value things that might not always be considered conventional progress outcomes. In the following interview extract, a nurse describes her most recent “strange success”:

Yesterday, one of my girls was shut in her bedroom. She had a bowl of fish fingers and tomato ketchup and chips that she was, the little one was, dropping in the drawers and rubbing on my coat – which was a bit annoying, and all that sort of thing. And actually, you know she said, “Oh I get told off about this because I get mess everywhere” and I said “Mmm. What do you think about that?” and she said, “Well she’s happy and she’s eating her dinner so at the end of the day...”. You know, and this is a child protection child, and they’re ramping up the concerns and everything, but she still had her focus on how happy her baby was - do you see what I mean? And in all our data and attempts to measure and capture and everything, they completely miss the point a lot of the time – you watch a sensitive moment and you think – that was really sensitive and lovely and I don’t know how I put that into words you know, it’s an unmeasurable thing you know.....

Yes, being gentle and compassionate when the world around doesn’t feel very gentle and compassionate, and they are somehow preserving that bit of their special heart for this baby and we do, luckily have the opportunity when we’re there in the visit to affirm that – I said “it’s so sweet the way you let her drop the fish fingers in the drawer” or whatever [everyone in the focus group laughs].

This nurse has learnt to tune in to her client in a way that allows her to notice and affirm intimate affective, relational parenting. It is possible to see how a deficit-based narrative might have framed this scene as one in which a mother, without appropriate boundaries, allows her child to throw around food, wrecking her rented property and wasting money. The family nurse’s skill here is in reading and understanding this situation with a completely different lens and being able to share this with the mother – affirming her choice to parent in a gentle and responsive way. This is a sophisticated interpretation of ‘making a difference’. However, it is notable that whilst this nurse believes that she is practicing the FNP model, she also believes that it is “missed” by those who seek to measure her work. This is frustrating to her, because what she notices, and values is not, she believes, noticed or valued by the wider managerial system within which she operates. This is suggestive of a separation in her mind between the FNP model as it is engaged with at the micro level and its wider implementational features, which include a requirement for family nurses to quantify their work.

This was not an isolated example. Several nurses gave examples of similar “strange successes” which involved facilitating subtle, internal shifts in clients. A nurse spoke about working with a mother as she came to the realisation that she was unable to care in the longer term for her baby. She described the paradoxical mix of pride and sadness she felt when her client admitted that her baby “deserves better than me”. Another talked about working with a mother during pregnancy and delighting as she began to realise that her baby was a “separate little person, with the ability to feel and have emotions”. These outcomes are heavily dependent on an intimate and mutually trusting emotionally attuned family-nurse relationship in which complex, new or painful concepts are processed. Yet another described how she discussed with a father his childhood experiences of being shamed when being disciplined by his parents, in the hope that this would encourage an empathetic response to applying boundaries with his own child. These are psycho-social processes which involve internal shifts which take effect in the external world. These effects are sometimes difficult to predict or celebrate – like a child being placed into local authority care. They represented the work that nurses were most proud of however, and that which they felt to be a true reflection of the value of their work. Despite this, there was a consistent tension between the value that nurses placed on particular outcomes and what they thought ‘others’ – be they commissioners, their supervisor, the NU, the ‘programme’ in general - considered to be of value.

In the extract below a nurse talks about how modifying the diet of a baby - an uncontroversial and straightforwardly positive outcome in FNP terms - still somehow feels like it represents a “small” if not “strange” success, in the light of the initial high expectations she had for what she might achieve through the programme:

You are set up that this is a wonderful [programme]... yes, there's a lot when I think back, it's all very, very, you know, like, high and great and, 'this is going to be amazing' and, 'you're going to do this, you're going to do that'. But now, I know to adjust a child's future... sugar intake from this programme is major. You know, like, it's the small things. To hear a mum that's obese herself and the whole family are obese talk about sugar and be really on it looking at the diet and how she tells her mum not to get... that is, you know, think about it? That's another generation. You're talking about obesity, diabetes, all the other things that come along with that

This data points to a modification by family nurses of the vision, from “changing the world one baby at a time” to something like “changing a parent one moment at a time”. This is not to say that nurses were not keen to affect change in the longer term: many could cite examples of how they were helping to raise self-esteem, break negative patterns, helping parents to love their children. However, nurses were aware of the limitations of what they could achieve, as one said, “We are part of a whole bigger system, so we tweak a bit”. The views of FNP clients presented in the last chapter suggests that this ‘tweaking’ is for many, incredibly life enhancing. However, the language here is strikingly low-key compared to the FNP vision to change the world. This data presents an opportunity for re-evaluating the role of this vision – a task that I take up in the discussion chapter.

Conclusion

This chapter builds on the previous one to present the contrasting and overlapping experiences of nurses in relation to their experiences of the FNP model. It has demonstrated how family nurses experience a range of feelings through their enactment of the model – they are vulnerable and powerful; they wonder if they are doing any good and also have a sense of making a difference. Family nurses are subject to a range of ethically conflicting scenarios connected to multiple accountabilities; the shifting social and cultural positions of clients; and the meaning of the ‘change’ that family nurses are there to bring about in their lives. At times, the individualised methods in the model, which can be very rewarding, also leads to

feelings of isolation and a disproportionate sense of responsibility for problems that are out of nurses' and parents' control.

Family nurses invest a great deal in their roles and have high expectations of it. When there is a mismatch between what they hope for and reality, they tend to respond by internalising the problem, rearranging their expectations or disengaging. They seem not to consider that they might contribute to changing the stigma, hostility or discrimination that their clients face, beyond opportunistic challenge or ad hoc advocacy. Neither do they seem to reflect on the effects that working with a client group thus affected might have on them. The organisational context places multiple expectations on nurses to account for their work and justify their value for money, and this, along with a depleted local support network, can make the role can seem overwhelming.

Nurses across the data set often expressed a sense that others fail to understand or appreciate their task. I hope that, apart from anything else, this chapter will contribute to a greater understanding and appreciation of the complexity of the role and lead to possible ways of strengthening horizontal and systemic support structures. The next chapter presents the data relating to the organisational implementation of FNP model, which for the first time includes data beyond FNP staff, to 'thicken' the description of the model further.

Chapter 6: Organisational and professional implementation of the FNP Model

Introduction

So far, I have presented the findings relating to client and family nurse experiences, focusing on micro-level/clinical aspects of the FNP model. These chapters drew from Stage 1 of the fieldwork – consisting of ethnographic observations and interviews that took place over an eight month period – as well as focus group material from Stage 2. In this chapter, I present findings about the wider organisational application of the FNP model, addressing the meanings attributed to it by research participants. These include both those involved in its direct delivery and those with related roles within the wider professional system. I will continue to draw on data from Stage 1, and from Stage 2, I will draw on interviews with four supervisors and the focus groups material that relates to stakeholders and staff. The chapter addresses professional understandings of the FNP model's clinical application as well as wider implementation issues, such as approaches to supervision and FNP's role in the wider system. For the first time, the thesis brings in the views of stakeholders - professional colleagues of FNP, who work directly with a team or with the same client group. They are drawn from the fields of health visiting, specialist nursing, midwifery, social work, early years, and the voluntary sector. From Stage 1, they also include representatives from commissioning, as well as non FNP professionals with managerial/supervisory roles in relation to the FNP team, including clinical supervision (by a Clinical Psychologist), managerial leadership (by a 'Provider Lead'), and safeguarding supervision (by a Named Safeguarding Nurse).

This chapter, therefore, draws on diverse sources to explore how the FNP model is operationalised within the wider organisational infrastructure which supports the clinical delivery. It provides a third-tier perspective of professional activity, which, from the perspective of clients could be thought of as 'behind the scenes'. My attempt at layering the data according to system level perspectives is intended to provide a solid structure from which I will launch my later discussion, which brings together common

threads and patterns from all three chapters. In keeping with the two previous chapters, the structure of the section headings corresponds to prominent ideas arising from the analysis of the data. Unlike these chapters, however, there is less direct quotation here. The reason for this is related to the imperative for internal confidentiality within FNP, whereby verbatim quotations could increase the possibility of those who took part in the research recognising their colleagues' comments. Given this is an organisational study focused on systemic obstacles and opportunities, it will inevitably involve critical reflection on certain aspects of the FNP model. This, along with the higher likelihood of the participants represented in this chapter reading the thesis means that I feel an ethical duty to protect their identity and avoid any sense that my observations be taken as a personal or organisational criticism. Therefore, whilst this chapter draws heavily on data, its presentation is often in summary form or condensed within the analytic writing rather than presented as verbatim quotes. This also reflects the fact that I rely more heavily here on my observational material than in the previous chapters, which is more discursive and less compact or 'quotable' than interview and focus group material.

The chapter begins by considering the meanings that supervisors, nurses, and other stakeholders attribute to its micro-level/clinical application. I then discuss issues related to boundaries, including managing the family nurse role and access to 'sister'⁹ services. Supervision and other forms of support follow this, as part of the wider implementation of the FNP model. The chapter concludes with the data relating to the role of local and national contexts, and their effect on the operationalisation of the FNP model.

A relational change-focused programme

In the previous chapters, I discussed how clients and family nurses place a high value on spending time together. They testify to how the frequency and length of time they have within the model allows for relationships to developed in a gentle and unhurried

⁹ 'Sister services' is used to describe those services that sit alongside FNP as 'siblings' within the organisational ecosystem, such as health or safeguarding. That women predominantly delivered these services adds its metaphoric appropriateness.

way. Likewise, supervisors and many of the related professional stakeholders also commented on the value of this aspect of the model as a very positive feature. For example, a Provider Lead (who delivers managerial support to the FNP supervisor) and Named Safeguarding Nurse (who provides monthly group supervision to the team and ad-hoc consultation) spoke positively about how the time that family nurses have to develop relationships, enables them to approach issues in a sensitive, gentle and indirect way. This contrasted, they said, to health visitors, who might only have ten minutes in a one-off visit. They felt that over time family nurses built relationships in which other roles, such as 'mother', 'aunty', 'friend' etc. were utilised professionally to engage and support young mothers.

Likewise, stakeholders spoke about how family nurses took on nurturing roles with their clients. Whilst this was generally thought to be positive, some stakeholders, for example, a Looked After Nurse, expressed concerns that some young people attach too intensely to their FNP nurse. She described a young person who said her family nurse was "like my big sister", and another who took nearly a year to "get over" the ending with her family nurse, and to start remembering the positive things. This links to the data from clients and family nurses about how building a close relationship has an emotional impact on both of them, due to the intensity of the bonds formed. For both clients and nurses this was particularly felt in the pain of the mandatory 'graduation' at the child's second birthday, especially in the context of few equivalent 'step down' services and the hostile social context in which young parents live.

Other stakeholders spoke in a variety of ways about the strength of the family-nurse relationship. A health-visitor within the stakeholder focus group said that family nurses form a relationship which echoes those "we used to form with our GP", i.e. consistent and trusted. Supervisors and stakeholders spoke about how the FNP model facilitates relationships in which nurses "believe in" young parents, even when it seems like everyone else in the system has "written them off". A supervisor described how clients consistently feedback how much they value not being "told what to do" by their family nurse, which is consistent with observations in the ethnography. In what sounded like a very painful and delicate case, another supervisor spoke about a family

nurse who had reported initial serious safeguarding concerns about her client to children's social care. Nevertheless, the nurse had kept the case open, retaining her relationship throughout the period of the child protection investigation, which included the nurse providing evidence in court. When the child was finally returned to her mother's care, the nurse continued to deliver the programme. This account was given as an example of the FNP model's client centred care and commitment. It chimes with other accounts from observations, interviews and focus groups where family nurses describe their attempts to tune-in to their client humanity within a context of systems that dehumanises and disrespect them. As I have discussed in the previous chapter and will return to below, the data consistently shows the way that family nurses care for, and about, their clients, and that this sometimes comes at a high personal cost especially in terms of emotional labour (Hochschild, 1983).

Although many of the professional participants who took part in the study - particularly FNP supervisors and nurses - highlighted how teenage parents are undervalued as parents and let down by services, they did not dwell on the hostile context of discrimination faced by clients. Their efforts to re-dress structural issues were seen in the way that family nurses' enhanced attunement to clients enabled them to advocate on their behalf. As one stakeholder pointed out, at the same time, family nurses have a "level of honesty with clients that other professionals shy away from". This two-way honesty-advocacy approach meant that the views of young people could be heard in forums where they might otherwise struggle to express themselves. The family nurses' preparatory work and groundwork, involving building respectful relationships, meant that they could also speak with consent on their behalf.

Alongside the importance of a relational and client-centred approach, supervisors and stakeholders spoke about the value of the structured, consistent and evidence-based programme. Although many stakeholders applauded the FNP model's non-directive style, at the same time the model was understood - across the professional data - as being about changing clients. In particular, the idea of inter-generational change was often heralded as the purpose of the model, so that relational work was seen in the

service of this goal. As a Named Safeguarding Nurse said, the model involves delivering a:

programme of care – in which you support change by helping a client to think about their life in the past, so that she hopefully feels better about where she’s been and feels – “I’m more able to help myself

Clients were understood to have grown up in problematic families, and this, if anything, was the focus of change rather than anything wider within society. Within this, cognitive-behaviourist and neuro-biological ways of thinking were used to describe the changes that clients were being asked to make, rather than, for example, systemic or ecological conceptualisations of human development and behaviour. A Provider Lead described the role of the family nurse as “just flicking a switch in the brain and rewiring to get them to see things differently”. However, whilst there was a consistent narrative around change, what exactly clients were being changed from and to, was not always clear. One supervisor admitted that:

not everyone needs to change massively, but they do all need to transition from being a teenager to being a teenage parent and adult.

This view points to a conceptualisation of change which is broader than the idea of ‘flicking a switch’. It describes the family nurse involved in the slower, more ‘ordinary’ process of life-cycle transition. Whilst this might indeed involve clients eventually seeing things differently, the focus within transition is on a process of growth rather than on modifying something deficient. As I will argue in the next chapter, this undervalued aspect of the FNP model aligns with my observations of home visits and fits with the client-focused, relational aspects of the model. The reason for the undervaluing of such conceptualisations might be due to how relational features are reconciled with the more prescriptive educational programme, as I discuss next in relation to boundaries.

Boundaries

Who is FNP for?

Several supervisors discussed the challenges they faced in recruiting and engaging clients to accept the FNP programme. This centred on how a programme reliant on building a sustained and consistent relationship with a professional can be made accessible for those young people who, due to their psycho-social history, are unable to see the value of, or have the capacity to maintain, such a relationship. They talked about feeling under increasing pressure from commissioners to prioritise potential clients who were considered most vulnerable – such as looked after young people, those who went missing, were sexually exploited, involved in criminality or had mental health difficulties. However, supervisors reported that the reality of working with clients with such experiences was very challenging. One spoke about her concerns for her newest nurse who had fifteen clients with “high levels of vulnerability”. These clients were juggling several mandatorily involved professional relationships and the supervisor questioned whether it was reasonable to expect that her nurse could engage these clients in the way that the model imagined. Her view was that the programme needs to relax its boundaries in favour of more nuanced expectations for clients with such complex needs. This might mean, she said, being flexible on the levels of ‘dosage’ and, instead of aiming for a reduction in subsequent pregnancies, focusing on achieving a full-term pregnancy with a reduction in substance usage and as good an ending as possible, if the child is eventually accommodated.

Similar questions about who the FNP model is for were raised by a range of stakeholders and there were some surprising contrasting views in this area. A Provider Lead, for example, was comfortable with the idea that FNP was “very good for a handful of children”. Similarly, a Named Safeguarding Nurse expressed the view that it was good for a “small proportion of young people”. I took this to mean that they felt that FNP is a targeted service, working with the few who are more in need of help. However, within the same local area, health colleagues working with vulnerable adolescents held a different view. Whilst they agreed that FNP worked with a relatively small number of clients, they felt that these were those with the *least* complex lives,

within the teenage parent population. This was because they felt that the FNP model severely limited some young people's access to the service. Echoing the views of some family nurses, they questioned whether it was realistic to expect some young people to choose a structured relationship with a professional. They described how many of the young people they work with have very little by way of prior positive relationships with trusted adults – professional or otherwise – on which to base the sort of intense psycho-social relationship which characterises the FNP model. They reported how young people that they had offered the programme to, had denigrated the idea of FNP, rejecting it because of the educational expectations of the programme, cultural differences between themselves and the family nurse and a general feeling of being overwhelmed and intimidated by the commitment to regular visits. They cited defensive sounding reasons given by young people for declining the programme after meeting a family nurse once, like “I don’t need it”, “I didn’t like her” or “she seemed posh”. These stakeholders regretted that FNP did not offer more imaginative ways of engaging these young people and were therefore unsure whether the model could help them overcome their intimidation, fear, and preoccupation with the social differences between themselves and the family nurse. As a result of these experiences, they felt that FNP was missing out on helping a “pocket of girls who really need it”, and it was the “worried well” - those who are already willing to engage and learn - who benefitted from the FNP model. Other stakeholders echoed these concerns about clients whom the programme might be ‘missing’. For example, a health professional, with considerable experience of working closely with FNP, said that those who “need the programme the most” are those least likely to recognise that they do. She acknowledged that it takes some young people some time to engage, and whilst she understood that there needed to be a “cut-off point” within the eligibility criteria, she expressed a wish that this could be more flexible to individual need than it is at present.

The participants who expressed these views spoke with a sense of frustration about situations when particular young people had declined the programme. This suggests that they are of the view that FNP *could* be of value, if only it could be accessed. They were, however, critical of the way that the model prioritised its own structure over the

individual needs of the client and had the impression that its task-orientation meant that nurses 'ploughed on' with the programme, even if a client's life was in chaos. They felt that the methods used were somewhat "old-fashioned" i.e. non-digital, or what might appear "weird" to some young people e.g. the knitted breast. Above all, they felt that the boundaries of the programme were too rigidly applied so that it came across to them as inflexible in its expectations of commitment and consistency of engagement.

This view was echoed by a social worker within the same local area who described having "coaxed" a young person into accepting the programme, only to encounter what felt to her to be the model's inflexibility. It was very disheartening, she said, to have made considerable efforts to establish a referral and encourage engagement, only for it to result in "yet another" experience of rejection for the service user. In this case, the family nurse had apparently withdrawn when she realised that the client's unborn child was likely to be accommodated, leaving the social worker wondering about whether FNP could address the needs of the most vulnerable young parents. She felt that this young person could have benefitted from FNP in terms of supporting her through the process of separation from her baby and could have had a positive impact on her care of future children – adding, with a sigh, that the young person is pregnant again, but is no longer eligible for FNP support.

The examples presented above point to the view held by some stakeholders that the FNP programme is rigid and overly structured in its eligibility criteria and methods. Likewise, nurses occasionally expressed similar views, about what they felt to be 'inhumane' aspects of the application of the model's 'rules'. Examples given were rejecting a very vulnerable young person because they were too advanced in their pregnancy, or 'graduating' a client who had just moved to a new area and had no other support. Holding in balance the 'rules' on the one hand and a humane approach to individual clients on the other, was a tension running through the data, causing ethical and moral distress. The social worker quoted above, for example, said that she felt that she had been "sold a dream and then told that actually there are so many conditions". There are some parallels here between the social worker's wish that the

FNP model would deliver a ‘dream’ and family nurses’ views of the FNP model as “dreamy”, as in, idealistic about what it can achieve. It raises questions about where such expectations hail from and the effect that they have on those accessing and delivering the programme.

This issue also highlights again, the existence of contrasting views about FNP within the data. Whilst some stakeholders, as discussed, experienced the FNP model as rigid in its boundaries and lacking in creative methods, their colleagues in another site area considered it to be humane and flexible. The fact that these views emanated from different local contexts, points to the influence of the local system. We have seen presented above for example, two contrasting situations: one where a client stays open to FNP whilst going through child protection processes and one where this is the given reason for ending FNP involvement. In the case that stayed open, the FNP supervisor buffers pressures to close the case and copes with corresponding anomalies in the data. The capacity and confidence to take such a decision, however, was not routinely available to all supervisors. These issues highlight differences in understandings about who FNP is for, its overall purpose, and how, as we have seen, emphases can shift from place to place according to the local context.

The family nurse role

Expectations about what is expected of family nurses also differed across different sites taking part in the study. Whilst most professional participants acknowledged the affective, relational element, the way that this was integrated and accepted into understandings of the overall purpose of the role differed. In one of the sites, there was what seemed to be a sophisticated understanding of the importance of developing an “emotional connection” with clients that allowed nurses to provide a “compassionate presence” – because as one nurse said, this is “what you’re trying to help them achieve with their babies”. In another area, however there was considerable turmoil and confusion around this issue. Whilst the clinical supervisor there felt there to be many very positive elements to FNP – particularly the knowledge and practical skills that nurses share – she also worried that it was emotionally

overwhelming for them. She described nurses with high levels of stress due to unclear expectations about the extent to which they take on responsibility for the wider (housing, mental health, safeguarding) needs of clients' lives. To help them, she focused a great deal of her attention in group supervision on supporting nurses to find realistic boundaries around their roles. In the following interview extract she discusses how working in clients' homes, viscerally exposes nurses to the needs of families, which they may not be resourced to help with:

- R: When we go and do outreach work, you....[are] inside of that family, aren't you?
- I: **Yes. In their home.**
- R: In there. Here [in the clinic] they come, it's a neutral setting, we have a task, we talk, say bye-bye, each goes their own way. But you go there – it's, "there's a man in the house", it's "the fear of the dog", it's "the baby crying in another room", you are part of that.
- I: **Completely, yes.**
- R: So, I think it's much more difficult for you to say, "Well this is it." You still have.... and I think they really.... and they are very good in this sense....but I think emotionally, it's almost impossible to say, "This is not part of my...." Once we step in, everything's part of your session, isn't it? And you cannot say, "I'm not going to get involved with that child that was sitting on the stair the whole time." (Remember one situation that one of the colleagues, very distressed, was saying the little sister was sitting on the stair the whole time?). I mean, you can't just say, you can't do anything, but you cannot feel, not feel, "Oh my goodness, this is a problem there." Because I saw, so I can't pretend I didn't see. But it's totally, totally *out* of what I came here to do.

Here the clinical supervisor worries that the FNP model asks family nurses to do something paradoxical, which is to not feel the things they feel and not notice the things they notice, which, she acknowledges, they cannot do. Her concern is around what family nurses are actually there to do, what their purpose is – the boundaries of their role. She seems to believe that their focus should be on delivering the FNP educational programme, rather than dealing with clients' "emotional, psychological, psychiatric" disturbance. These, along with the vast practical issues such as not having

anywhere to live, not having a GP, needing to arrange contraception, sorting out immunisations etc, are overwhelming. She wonders if perhaps the model was developed in a context where clients were less vulnerable, making it more straightforward, more likely to 'work', though ironically the opposite has also been suggested as a way of understanding Building Blocks FNP RCT outcomes (Robling *et al.*, 2015). She spoke about how family nurses worry about and feel responsible for aspects of their clients' lives that they cannot in reality help with, and then internalise this as a personal sense of failure, in the context of a model promising that they will change the world.

This view was echoed by a Named Safeguarding Nurse when she spoke about the fluid nature of the role and how family nurses, because they are "so caring", often get involved in areas of clients' lives that a health professional "would never normally support them with". Similarly, the Provider Lead also expressed her view that nurses sometimes became "too involved" with clients, echoing the worries of stakeholders presented above about young people becoming similarly "too involved". This involvement she says, makes it difficult for nurses to "separate themselves", although this was not surprising, given the levels of investment they had in their clients.

The clinical supervisor believed that her worries about the boundaries of the family nurse role were shared beyond her local context. Recollecting a rare conversation with others doing the same role as her in different locations, she said:

And it was very interesting because with little differences [between the experiences of different FNP clinical supervisors] but we're all doing more or less the same thing. And we had all travelled to looking at them [family nurses] as they gave them a plate and they put much, much more on that plate than the size of the plate they were given.

We see here a metaphor of a process in which there are tensions and paradoxes, and where lines of accountability and responsibility are blurred. Eating food is a particularly interesting image to use, because of its associations with mothering and the maternal (Kristeva cited in Oliver, 1992, p. 68). It suggests that family nurses begin with a sense of individual agency and desire for nourishment. Rather than being able to select what

they need, however, someone else is loading it up. The plate is too small, they cannot hold all this food – so what are they to do with it now? Can it continue to nourish, or will it turn sour, will it make them sick if they try to stuff it all in? In this way, something which seemed pleasurable and nourishing becomes oppressive, and there is a loss of boundary between agency and desire. This links to the idea, seen in an earlier quote by the same participant, of how families and nurses get “inside” one another. This blurring troubles her and she wishes family nurses to be less porous, less entangled, to be able to choose what goes on their plate and what gets inside them. During observations, I saw this supervisor grapple with the team’s struggles. She wanted family nurses to accept that some things are beyond the remit of the programme and to protect them from self-doubt and self-blame for not being able to make more of a ‘difference’. Despite her struggles however, in keeping with family nurses and supervisors, she too loved her role. She had deliberately held on to it, as she let other roles go, when reducing her working hours. Significantly then, FNP had ‘got inside’ her too. Even though she seemed to have more control than nurses over the size and content of her ‘plate’, she shared a similar passion and commitment to the work that was seen in the staff team.

An interesting finding when looking at the data from professionals as a whole was the way that proximity to the clinical work seemed to affect views about FNP. Research participants who had minimal contact with FNP tended to be relatively critical of the model – e.g. the social worker cited above. Those who were closer to the work, but not involved in its delivery – e.g. the Named Provider Lead, or a community midwife who made regular referrals to the service – expressed very positive views about the model. A third group, those who were directly exposed to, or involved in, the clinical implementation of the FNP model, demonstrated ambivalent, contrasting and conflicting views, e.g. the clinical supervisor above. Sometimes, therefore, the views of those very close to the clinical implementation mirrored those who were further away – such as family nurses and a specialist health nurse both experiencing the model as “rigid”. This highlights the complexity involved within the application of the FNP model so that it is viewed as ‘messier’ by those close to its clinical implementation than to those at a slight distance – who are perhaps defended against the ‘messiness’ for

various reasons. Paradoxically however, conflicts and tensions are also more visible to those who are further away. This is explained, I would argue, by the complexity of accountability structures within the local environment, as developed in the next section through an exploration of the supervisor and support structures within the FNP model.

Supervision and other support structures

Parallel process through one-to-one supervision

From my first encounters with FNP, the supervisory element of the model was impressed upon me as being integral to the success of clinical outcomes. Its importance and uniqueness were articulated across the data set by clinical leads, supervisors, nurses and external stakeholders. It was widely understood and acknowledged by nurses, supervisors and stakeholders that the FNP model is demanding in terms of the emotional and relational aspects of delivery, requiring sensitive and differentiated containing support structures. This was understood as both important for the health of individual nurses but also integrated into the clinical model, linked to the idea of relational parallel process, as described here by a Nation Unit clinical lead:

[it is a] process whereby all relationships impact on others. And the model is designed intentionally so that that relationship between the family nurse and the client models for the client, and parallels, that kind of safe base that you're hoping the client will provide for her baby, in simplest terms. And that then the supervisor models that for the nurse.

Supervision, therefore, is not understood within the FNP model as simply an activity to alleviate the anxieties of nurses – although it is hoped that it will serve this function. It is also understood as instrumental in developing their capacity to pass on, model, mirror or parallel what they receive in supervision – described here, using attachment theory, as a ‘safe base’ (Bowlby, 1988) – to clients. This, in turn, it is hoped, increases the client’s capacity to provide emotionally and psychologically for her baby. One outworking of the commitment to this process was how, across the sites, supervision and team learning took place at the same time every week and was missed on very

rare occasions. Indeed, within the ethnographic site, an attempt to maintain a consistent weekly structure was such a priority for the supervisor that she saw all the nurses on the same day without a break – putting the needs of the model structure, as she and her team interpreted it, before her own. Supervisors spoke about how this consistency was part of their intentional effort to model a containing structure that mirrors that which nurses deliver to families.

Supervisors gave the strong impression that they see supporting and enabling workers as a key part of their role. Some supervisors talked about supervision as having an almost therapeutic role – for example, one talked about how the programme is “as much about the nurse as it is about the programme”, while another talked about the role of supervision in helping nurses to face up to the things which “push her buttons”, i.e. those things which are unsettling in the course of her work. Supervisors talked about how they too felt that they had been ‘invested in’ at the start of their FNP career when the training they received modelled the values of the programme. Some supervisors had a strong sense that they help nurses to integrate “deep learning” – i.e. the emotional and cognitive aspects of the programme, within themselves.

Supervisors emphasised the importance of investing in trusting, respectful and honest relationships so that nurses could offer this to clients. In the following extract a supervisor describes in detail how her team embody the idea of an empathetic, caring and respectful relationship:

for me, it is about the whole structure around the nurse and the parallel process, but also, that humility within a professional who’s nursed or been a midwife for years, who still has that humility to go in and say, “You know what? I’m hearing what you’re saying. I understand why.” And that is your choice.

Supervisors recognised that their approach is generally at odds with the wider professional environment, in which learning is a ‘tick box’ exercise. In contrast to this, they were trying to foster a “learning culture”, where workers are treated with respect and supervision is a place of genuine learning. Perhaps because this approach to

supervision is so at odds with the wider NHS culture, supervisors spoke about their determination for it to remain at the heart of their practice.

The extent to which it was possible to trace parallel-processes of containment and support within sites was, inevitably, highly complex. Whilst it was not my intention to evaluate the 'success' of the model in this way, I do wish to comment on the day-to-day outworking of this programme ideal in practice. Certainly, as I have said, the data shows that FNP nurses and supervisors all recognise the value and importance of regular, reflective supervision. They understood that it could mitigate the risks inherent within the family nurse role such as isolation and 'burn-out'. Some nurses provided specific examples of how supervision was helpful. One nurse spoke about how her supervisor noticed and reflected on her transference behaviour with helpful effect. Here we see the idea of parallel process flowing from the client's experiences up through the system to the nurse during in supervision. Her skilled supervisor notices this, helps to emotionally contain it, and the hoped-for effect is 'paralleled' back in the other 'direction', such that the nurse's clinical practice is enhanced by her deeper understanding of, and ability to emotionally contain, her client's difficulties. Similarly, another nurse felt that supervision was "somewhere to talk about how [the work is] making you feel". Some nurses described how the purpose of this emotional holding enabled them to protect clients from the pressures they themselves experienced. They felt that it increased their capacity to 'buffer', for their clients, certain anxieties or concerns – much as a mother or father does for their child.

Complex expectations

Whilst the data shows that a great deal of time is given over to supervision and that it is treated as sacrosanct - in accordance with the FNP model - some nurses expressed doubts about whether it could achieve all it set out to do, in terms of providing the kind of reflective, containing and emotionally informed space described above. As I have explained, this was in the context of supervision being seen as the FNP model's primary route for developing affective and cognitive learning - which is either 'scaled down' through parallel processes to FNP clients or 'scaled up' through relationships across the professional system. Therefore, although training, weekly team meetings,

monthly group supervision (facilitated by either a clinical supervisor or a safeguarding nurse) and informal peer support were all available as containing spaces beyond one-to-one supervision, the frequency, length and protected nature of one-to-one supervision between family nurse and FNP supervisor created the effect of elevating it above all other forms of support. At times it seemed to take on a reified status – similarly to weighing babies within the clinical application of the model - as something which is ‘believed in’ beyond its actual capacity to deliver.

Both nurses and supervisors commented on how the structure of the FNP model placed high expectations on the role of FNP supervisor. The focus on the supervisor-nurse relationships mirrors the importance generally throughout the model on one-to-one relationships for enabling change - be it mother and child; nurse and client; or supervisor and family nurse. In supervision, this emphasis provided opportunities for in-depth relationships to develop but also ran the risk of placing unrealistic expectations on the supervisor-nurse dyad. Supervisors spoke about how the model relied on high levels of containment, emotional intelligence and reflective function being available to them. Across the data, there were contrasting experiences in terms of how equipped and supported supervisors felt to take up this aspect of their role. One supervisor, for example, noted that her own clinical supervision was monthly, whilst she was providing weekly supervision to multiple nurses. It felt to her that there was a deficit in terms of what she was being asked to give, compared to what she received. The supervisor is positioned to absorb professional anxieties from within the team (which may emanate from the distress of clients) whilst also being exposed to external pressures from the wider organisational functions (data oversight, commissioning relationships etc.). This places considerable expectations on the role - conceptualised as a ‘bottleneck’ in Figure 3 – whereby important containing, mediating and ameliorating relational processes are expected to ‘pass through’ the site supervisor.

The challenges faced by supervisors in executing their role came from an interplay between several factors. One of these, as discussed, was the role’s location at the boundary between the FNP team and a wider environment, in which being strengths

and relationship-based created a feeling, to quote one supervisor, of being “a square peg in a round hole”. The other aspect was the personal capacity of the supervisor to undertake reflective, emotionally intelligent supervision, which was in turn, affected by the wider context. Linked to both of these is the structure of the FNP model at the meso level, where the containment available to supervisors is structurally fractured. Supervisors commented on a reduction in supervisor learning days available from the NU for example, and another on how maintaining peer support relationship with another site was quite an effort, something that she had to ‘make happen’. In terms of the containment that came from the provider site, this was unpredictable, with one supervisor commenting on how Trust management expected workers to “care for vulnerable clients but they don’t care for us”. This poignant statement caused me to wonder if this supervisor felt uncared for, and whether the role of caring for her staff team is sometimes undermined, rather than facilitated, by her context.

Figure 3 shows how the FNP supervisor role is set up to provide weekly professional containment for several nurses. Not included are the containment expectations in relation to supervisors’ own clients, as well as to other staff, such as administrators. Therefore, whilst supervisors are expected to provide a great deal by way of emotional support to others, the containment available to her is more diluted. Monthly clinical supervision is the main source of support – hence its larger size, but as it takes place much less frequently than the supervision she provides to nurses, it is placed on the figure at a relative distance from her. All other forms of support, as the arrows indicate, also require the supervisor to deliver or provide something in return, thus reducing the likelihood that this will be experienced as exclusively supportive. For example, a relationship with an FNP NU representative might be experienced as both potentially containing and demanding by a supervisor, due expectation on supervisors to meet certain quality standards overseen by the NU. As I have noted, many of the sources of potential support for supervisors are also highly unpredictable – as I discuss below in relation to commissioners. Indeed, one supervisor, describing uncertainty within the role said, “if you expect regular 8-4 office hours – it’s not going to happen!”.



Figure 3: Direction of organisational containment and support in the FNP model: a supervisor's perspective

The role requires supervisors to 'face' in several directions at once – towards clients, nurses and other staff, Trust managers, the NU and commissioners. One supervisor described this as having different "hats to wear". Sometimes, she said, "my hats change so quickly, I feel like I've forgotten to swap and I'm in the wrong mode". The 'hats' posed challenges not only in terms of their quantity but also in their contrasting qualities. For example, a supervisor might be required to listen with empathy to a client in one moment and scrutinise budgets the next. The role therefore, required both having the emotional capacity to support others – whilst receiving relatively little in return – and a very broad set of clinical and managerial skills which can be utilised fluidly and confidently.

Taking up this theme of attire, I noticed during ethnographic observations how the supervisor tended to dress more smartly than her family nurses colleagues. When we spoke about this, she explained how she used to come to work on 'office days' in dresses and in trousers on 'client days', but this became complicated and often clients swapped visits at the last minute. The question about which clothes to wear and the possibility of being too smart for home visiting or too casual for management meetings seemed to symbolise the complex multiple accountabilities within the role, causing her

to ask herself “Which self am I?” and “Can these many roles co-exist in one person?”. She felt caught between being a part of the FNP team and being a Trust manager, which felt isolating because she felt herself to be neither one thing nor the other. The confidence with which supervisors felt able to integrate the various elements of their roles varied across sites – a pattern that is in keeping with the broader data set.

One of the common features of the interviews with supervisors was a belief in the ‘scientific base’ underpinning the model. Whilst it is part of received good practice to be aware of evidence bases, and FNP promotes their RCT credentials, from a psycho-social perspective it is also possible to see this as an outworking of anxieties generated by the role. I wonder if FNP’s scientific base provided some supervisors with a kind of containing safety net if more relational means of holding were not available to them. As with many of the issues discussed in this thesis, there is nothing inherently problematic about drawing on an evidence base. However – as was seen in the aftermath of the publication of the first stage of FNP’s RCT trial – an over-reliance on quantitative research, within the context of a complex relational intervention, can be problematic. When there is uncertainty, and uncontained anxiety supervisors may turn to the programme as if it is a formula. This however reduces the possibility for reflection, and humane, responsive and relational working. Working creatively with this tension is a very difficult task, which I address in the next chapter.

Beyond supervision

The issues discussed above inevitably impacted on both supervisors and family nurses, who found individual ways of mitigating the disparity between expectation and reality in relation to supervision. Some nurses and supervisors expressed their doubts about the supervision structure, but it was notable that their response was to either leave, to try to make the best of it or to attribute individual blame. As a reified feature, supervision was *meant* to work, and there was an absence of noticing that this might be a structural or systemic issue that could be changed or critically appraised. Where it was not working, nobody felt able to talk about it collectively or do anything about it. Similarly, I interviewed a stakeholder who, in a previous role had been an FNP nurse

(not within any of the sites taking part in this research). She spoke about how, rather than sharing their feelings with their supervisor, she and her colleagues learnt to withhold them, in a bid to protect themselves and her from the ensuing emotional escalation that would come from sharing with her.

Inevitably perhaps, a high sense of expectation, set up by the FNP model, seemed to lead to correspondingly high levels of personal disappointment, when what was promised failed to 'deliver'. I was struck by how this feeling had also passed to the clinical supervisor in one site, who, like nurses, confessed to worrying about whether she was 'doing it right'. The struggle to find a 'good enough', depressive position about what was possible through the model, echoed some of the nurses' experiences of the way that they had been led to believe that they would bring about "dreamy" transformations with clients, only to find that in reality what they could achieve was more modest. In both cases the 'failure' was carried in individualised ways, perhaps an unintended consequence of the focus in the model on the role of individuals to bring about change, as discussed elsewhere.

Although nurses sometimes experienced disparities between expectation and reality, they believed that their original training had "stood them in good stead". According to one nurse, it was "the best training I have ever had". Nurses expressed how they had felt invested in and special, "so that we could invest in others". Nurses' experiences of having an ongoing relationship with the wider FNP community and/or the NU was minimal, however. One nurse spoke enthusiastically about a one-off conversation with a nurse from another site, which had given her the confidence to take up a particular action, but this seemed like a rare, and almost clandestine, experience, rather than a routine part of her role. Others spoke about a sense of loss at the reduction of support from the NU, which they had experienced as a safety net, whilst others did not seem to expect this type of support.

As might be expected, nurses often drew on the informal support of their peers. Within the ethnographic site, this was enacted within one-to-one allegiances, whilst the focus group site nurses expressed a sense that the team as a whole was a

supportive network. The focus group site valued time set aside within team meetings for skills practice. Learning and thinking together as a team was much more problematic within the ethnographic site. Coming together drew attention to tensions within the team's dynamics, including splitting – which was a considerable affective preoccupation the whole team. In addition, the effects of a facilities re-structure, which involved the team losing more than half of their available space, and increased remote working and 'hot-desking', made it much harder to be together as a team and to access informal peer discussions. Across the sites however, nurses were optimistic about the potential of peer-support for nurturing collective ethics; developing and sharing knowledge; and general emotional revival. However, there was also a sense that peer support was less important within the FNP model than individual one-to-one relationships and was, therefore, harder to value or hold onto. In my discussion chapter, I will return to the potential for collective action within the FNP system, in which solidarity between nurses could be a way of ameliorating the effects of individualised ways of working.

The impact of the local environment

There were notable contrasts between how the model was interpreted and understood according to the local context of the site in which the data was gathered. This was exemplified in the data from two health visitor managers within different FNP sites. One was of the view that FNP provided a service very similar to that of health visitors – the only difference being that they visited more frequently. The other demonstrated detailed knowledge and appreciation of family nurse practice, saying that FNP empowered colleagues from other disciplines to think differently about their communication style. Another example is how safeguarding referrals from FNP were treated in two different sites. In one area, referrals from family nurses were respected and taken very seriously, due to an understanding of the "tight" programme and frequency of visits, leading to an intensification of social work involvement. In another however, there was a sense that social workers "tend to take a step back" and dismissed family nurse referrals. It is not difficult to see why this latter scenario gave

rise to anxiety amongst the nurses in this site with regards to shared safeguarding responsibilities.

According to family nurses and supervisors, one of the key influencing factors on the local organisational context was the commissioning arrangements. This in turn, was influenced by a national context of austerity/reduction in funding for public services. At the local level, I observed the effects of this on sites in at least four ways: a reduction in the support available from the NU following significant cuts to their budget; a reduction in local support services to 'shoulder the burden' alongside FNP; the threat of being decommissioned; and the increased complexity and vulnerability in the lives of clients due to a reduction in welfare services, such as universal youth services. However, whilst local sites were inevitably affected by issues from 'the top down', the NU intends that FNP values and practices can influence the system, from the 'bottom up'. It is, therefore, to the role of FNP within the wider system that I turn to next.

The FNP model reflected within the wider system

Within the NU, senior leaders spoke about the importance of embedding the FNP model locally. This was thought about both in terms of particular activities such as a 'knowledge and skills exchange' training programme for non-FNP teams; as well more broadly in terms of influencing the wider system to adopt strengths-based approaches. The responsibility for leading on this work sat with the supervisor, with support from the Advisory Board. Despite having a relatively small budget and team, some supervisors described considerable strategic influence within their local system – evidence of which was borne out within the stakeholder focus group. This group demonstrated considerable knowledge and commitment to FNP, agreeing readily to participate in the focus group and speaking candidly about the service. FNP supervisors and family nurses stood out from other colleagues as confident and self-assured, they said, with superior skills in sensitive communication. In another site however, it was much harder to access local stakeholders to speak to about FNP. This pointed to a local environment under pressure, which, in turn, led to a more transactional and less relational contact between services. A social worker explained to me for example that

the reason so few of her colleagues seemed willing to speak to me was because they had not “used FNP”. This struck me as interesting phraseology, implying a commodified view of FNP, rather than the expectation of partnership, which might have been implied had she said, “worked with”, instead of “used”.

A contributing factor to the FNP model’s wider systemic influence is the structure of local sites. Although there is a UK licence holding teams to account, there are also local factors which influence the culture and direction of a site. These are factors which have limited input or training from the NU or contact with the wider FNP network. An example of this is the clinical supervisor discussed above, who had considerable roles for containing nurse and supervisor anxieties and supporting them to understand the parameters of their role but had only attended two FNP specific training events in four years. Given how fluid understandings of the FNP model have shown themselves to be within this data and given the context of anxiety emanating from both the clinical work and the managerial context, the idea of who is influencing whom, and to what end - both consciously and unconsciously - is revealed as highly complex.

One of the interesting differences between sites that seemed to be well-regarded and established within their local system and those struggling to find partnerships was the extent to which the FNP supervisor encouraged family nurses to work beyond the micro level and influence at the meso level of the organisational system. For example, within a site which seemed to have a positive local profile, the FNP supervisor spoke about how family nurses represented the team within local forums to “mak[e] sure these places are purposeful and that the policies and guidelines which come out of them – not just in health – are influenced by FNP values”. In another site nurses took part in multi-agency auditing of care plans where they could offer an “FNP perspective”. The supervisor spoke about how she had invested time with key senior managers – and training for family nurses – to achieve the level of trust necessary to underpin the formal and informal exchange of knowledge and skills. She was of the view that nurses could expand their roles in this regard further, for example, by hosting peer-support events with neighbouring FNP sites.

In the sites that seemed to have strong support in the local system, the supervisor was involved in considerable skills sharing herself. In two instances, supervisors occupied supervisory roles in non-FNP teams. Other systems work included developing a non-FNP pathway with health visiting, which was necessary due to all teenage pregnancies being directed to FNP for initial screening. This was, according to the supervisor, the result of “a lot of persistence with midwifery, a lot of bridge building, a lot of ticking boxes around governance”, and at the cost of considerable extra work involved in triaging a very high number of referrals. This scenario sat in contrast to another site, in which there was a significant reduction in referrals to the team, but very little apparent means of finding out why. Therefore, whilst some supervisors and their family nurses were confident to engage proactively with the wider meso system to undertake strategic influence within local networks, others seemed less able to do so. This suggests an interplay between particular meso and macro environments, interpretations of the FNP model and the way that these interplay with the particular characteristics of supervisors and teams. Figure 4 provides a visual display of the interdependence of the factors which contribute to a local environment.

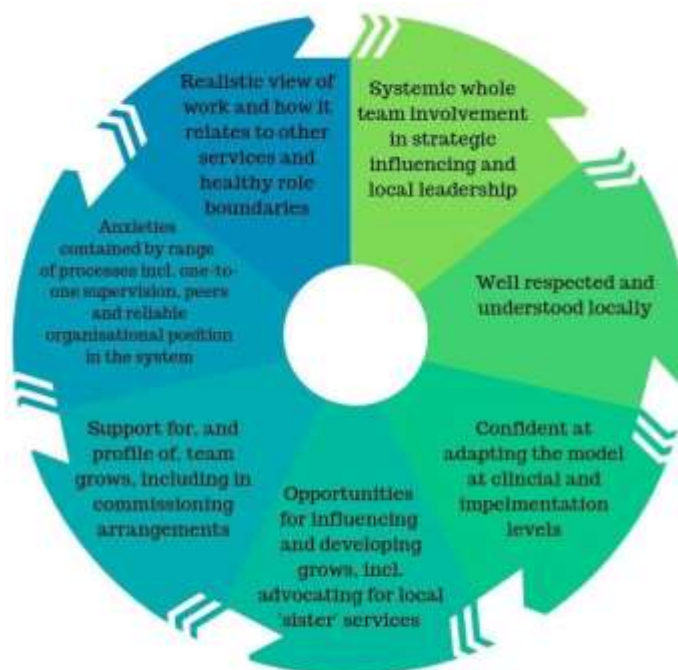


Figure 4: The dynamic interplay between internal (team) and external (wider system) factors at the local level – a positive cycle.

This is not to say that those sites that seemed less 'successful' in this area did not engage with meso level system work. For example, in one such site, the Provider Lead had adopted the FNP practice of involving service users in recruitment processes, which had been alien when it had first been introduced to her. However, despite this, neither she nor any of the other supervisors in this site were engaged in any formal or explicit ways of sharing FNP expertise, and 'FNP expertise' in this sense was left fairly undefined. A family nurse in the same site discussed how she felt her way of communicating with adolescents could be shared with others, but she was not aware of a mechanism for doing this. In keeping with the views of stakeholder focus group participants, a Named Safeguarding Supervisor reflected on the potential for holistic implementation of on-going training and consultation provided by FNP nurses to the wider workforce, for example about holding difficult conversations. She also expressed her wish that there might be some sort of 'step-down' FNP available, for clients ending the programme or with less intense needs, whereby nurses could be available at a reduced rate. However, whilst there was evidence of interest and skills to undertake such system level work, as described, there also seemed too significant a barrier to moving this forward, in this site.

Another interesting finding in this area was that those FNP teams where nurses were involved in work at the meso level also seemed to be more confident in their clinical application of the programme – such as feeling able to 'flex' the use of facilitators according to their professional judgement. In a contrasting site however, where family nurses were not routinely involved in local leadership work, nurses were less confident about the expectations and boundaries around the clinical aspects of their role. Even within those sites that were more successful in this area, there was confusion and frustration with regards to trying to influence the wider system. One supervisor reflected, for example, on the factors that inhibit her team:

Operationally people get it and at the strategic end, the Local Safeguarding Children's Board – our message is there. I think it can be in the middle that things get lost, and I do wonder why are we struggling to get our message through. Is it because everyone is having to deliver with limited resources and to tight time scales?

This data links in with my earlier observation of how a participant's relative closeness to the clinical delivery of the programme seemed to affect their view of the FNP model, as mitigated by their particular role within the system. Illuminating this, the supervisor here discusses how the local system can give rise to envy when, in a climate of austerity, battles over scarce resources are 'pushed down' and played out between practitioners, who become like rivalrous siblings (Stokes, 1994). It was not uncommon to hear family nurses discuss how professionals from other services were jealous of them due to their considerable contrast in caseloads and salaries. Within one site, family nurses spoke about how commissioning FNP had coincided with the closure of a well-respected teenage pregnancy service. This led to resentment from those involved with this service, that was still evident several years later. It created a feeling by the FNP team that they had displaced colleagues from their roles. This context increased expectations on them to 'prove' that they were 'worth' the disruption – adding to the complex accountability experienced by nurses, as discussed elsewhere. These systemic and historic issues were laden with unresolved feelings, including guilt and envy. They had an ongoing impact on the way that the site related to the wider system and contributed to external stakeholders' understanding of the services. What seemed evident is that an absence of careful management of transitions between commissioned services caused considerable 'under the surface' turbulence within the local implementation of the programme.

Power dynamics

Although all of the sites in the study felt fortunate to have "good" commissioning relationships, there was a sense that this could change at any moment. De-commissioning was an ever-present reality, causing anxiety and increasing the sense of responsibility held by supervisors for their team's survival. Two supervisors spoke about previous commissioners who had been critical and hard to engage with. They

expressed much relief that their current commissioner seemed 'sympathetic' to FNP. Given that the teams in question operated in the same way under both commissioners, yet received very different responses from them, there was anxiety around the unpredictability and vulnerability associated with a change of personnel which was outside of the supervisors' control. It was clear that managing commissioner relationships was a stressful aspect of the role, and that there were unequal power dynamics to negotiate. Within several of the sites, this was somewhat mitigated by steady and supportive Provider Lead relationships – where supervisors felt similarly "fortunate" and did not take them for granted.

I was struck by how, when talking about feeling "lucky" to have a sympathetic commissioner, supervisors did not refer in any way to how commissioners might be equally "lucky" to have FNP fulfil their responsibility for providing teenage parenting services. In two observations of interactions between commissioners and FNP teams, this power imbalance was also characterised by gender imbalance, in which there was a single male commissioner in the company of a female FNP team. Cultural differences between them were apparent through language and clothing – the commissioner in a formal suit, speaking in political managerial terms; the FNP team in casual office wear, speaking emotively about individual clients. I felt awkward, embarrassed and protective of the family nurses – and as discussed in the previous chapter – as they sought to persuade commissioners of the value of their work. An extract from my field notes reads:

This is something I've seen before at another FAB board –the female family nurses all sort of bearing their professional souls to male besuited commissioner/s. It feels to me like an uncomfortable dynamic. These are professional women doing a professional, well-paid role – why do they need to persuade others with emotive case studies in order to get recognition?

This dynamic is significant in that it contextualises the way that the FNP model is being enacted within a precarious environment where there are complex power structures and accountability expectations at play. Whilst these can be hard to see, they are nevertheless present within relational dynamics, and, as the next chapter develops, play out across the FNP system in a variety of relationships.

Sister services

As I have discussed, the wider commissioning strategy concerning FNP's 'sister' services has had a significant impact on FNP functioning. Within one site, for example, having a "good" commissioner could not mitigate the effects of the dramatic reduction in universal early years, leaving the local system under immense pressure and creating a sense of loss and shock at the pace of change. The ethnographic site, for example, felt particularly bereft in this regard:

D [family nurse] talked about how frustrating it is that there is a dearth of wider services to refer clients to – no father's service, no smoking service, no young parents group. She said this puts the FNP relationship under pressure because there is no other service available to support

As explored in the last chapter, working in an environment like this creates a great deal of anxiety and pressure on family nurses and contributes to feeling that they have to "do everything". This then makes their need for containment and the imperative to adopt a depressive position within their work even more pressing, but, ironically, this also increased pressure on the supervisor, making the availability of a containing function less likely.

National environment

As the UK FNP licence holder, the NU has both an influencing and supporting role with local sites. As far as sites are concerned, the NU is the provider and developer of programme material, as well as acting conceptually as the 'parent' organisation. Along with Key Performance Indicators or equivalents, which are set by local commissioners, sites are responsible for providing the NU with regular data on their performance – the "data dashboard", which is also used at a local level to support Advisory Board conversations. A range of factors mitigates the NU's influence on sites, however. These include macro and meso governance and funding; policy and socio-cultural environments; the capacity of supervisors to function within their multiple areas of responsibility; and the experiences of individuals involved with the programme at the micro/clinical level – be they clients or professionals.

My observation was that in some sites the relationship with the NU seemed at its liveliest around data-related expectations, with the periodic returning of statistics generating considerable affective energy for supervisor and staff. Possibly in response to this, one supervisor spoke about working hard to ensure that her nurses “love their data”. This was founded on her view – shared by other supervisors and NU leaders – that the data provides a trustworthy and accurate picture, alongside case study material, of site performance. This was somewhat complicated by evidence within this study that some nurses struggle with, and do not always manage to comply with, the requirements of NU data recording. This was linked to nurses’ sense of frustration at the type of information that the NU required, such as setting a numerical figure quantifying the content of each visit which they felt diverted them from caring about clients to “caring about the data”, as discussed.

Certainly, at the NU level, there was an intention for data from sites to be meaningful and useful, and for the flow of information to inform the strategic deployment of resources and activity. One NU leader spoke about the challenges of meeting the expectations of the NU’s own funders for data about overall FNP activity. Such challenges included a climate of reduced NU resources with which to try to gain a coherent overall picture of decentralised and diverse FNP teams – who have numerous competing demands in terms of local expectations around data recording – as discussed. The NU’s role in providing strategic direction of FNP and its need to maintain an accurate picture of national activity, adds to the complex accountability structures within which the model operates.

NU leaders intend that the FNP model – its values and key approaches – to be integrated into their leadership, to maintain the principle of parallel processes, as discussed earlier. This involves an interest in modelling values such as relationality, humility, self-efficacy and valuing strengths. The following quotation provides an example of this communication style, spoken by an NU senior leader, to which I have added a brief analysis based on the values listed above, in parentheses, to show how this type of modelling and embodiment plays out { }:

So, I think we've got a lot to say, and I think we're doing really interesting and ambitious and exciting work {self-efficacy} but I also think we've got an awful lot to learn from other people {strengths-based, relationality, humility}. I think as part of the looking outward, it's not just fending off, it's also bringing in, I suppose, as well {humility, relationality}.

Here the concept of 'fending off' builds on an earlier part of the interview where this participant described the role of the NU in 'buffering' pressures from the outside. Later she explains that the NU works hard to "protect the space" that sites need to undertake work which is slow and subtle because it is based on developing relationships and involves reflection - within a welfare climate favouring short-term, quick solutions. The idea of providing a buffer to protect others from a harsh context is a theme mirrored throughout the data set across system levels – for example, the client who allowed her daughter to post fish fingers so that she can explore the world and the family nurse who protected her from the criticism of others for doing so. The concept extends beyond defending into the possibility of enabling the growth and development of the one being 'protected'. Within the operationalisation of the model, therefore, we see an intention to create a dynamic space for clients, in which family nurses absorb and mitigate pressures on their behalf. This is a relational process that enables slow, delicate and subtle processes to take place, within the safety of the space created.

Within the quoted extract above, the participant describes how the NU also seeks to lower defences by "bringing others in". Within psychoanalytic thinking, psychological defences such as splitting can be overcome through the containment of the anxieties that generate such defences – a concept which underpins the supervisory structure, as discussed. However, the data suggests opportunities for enhancing the NU's role in terms of providing a wider containing organisational context. For example, whilst there is a clear expectation, and embedding of, reflective discussion at the site level, this aspect is more *ad hoc* at the NU level. Whilst there are important differences between clinical and business support roles, there are organisational changes - for example, those that involve imposed restructure – the impact of which will be felt and held throughout the system. The NU, therefore, has an opportunity to develop the

parallel-processes conceptualised within the model – by developing its own reflective processes – in order to contain emotional turbulence and mitigate the ‘trickle down’ effect of organisational defences against anxiety (Menzies-Lyth, 1959). FNP’s reflective and relational leadership style and non-defensive approach to wider community engagement provide a strong platform from which this could develop.

However, as has been evident throughout the data, the FNP model encapsulates ideas and methods that are not always easily integrated. For example, one senior leader spoke however about how “working relationally” could be a euphemism for avoiding challenge within the NU. This either/or between ‘relational working’ and ‘challenge’ was reflective of similar binaries at the clinical level linked to the idea of offering emotional, responsive support and delivering the educative elements of the programme, which are bound up in some of the difficulties which nurses had with the boundaries of their role. This indicates that certain common features of the FNP model move ‘up’ and ‘down’ throughout the system.

Working with, and within, binaries was understood and reflected on at the NU level, informing their development activities, and was sometimes thought about in terms of integrating the ‘hard’ or ‘soft’ elements of the model. This is where ‘hard’ might be encapsulated by the idea of a manualised educative programme and ‘soft’ might be a client-led, individualised relational, responsive approach. The data presented within all three of the findings chapters has pointed to an organisational model which has the potential to veer towards one polarity or the other when under pressure, and to the challenges involved in integrating them, or holding them in balance, together.

NU leaders understood their task to be about supporting the organisation to do this balancing work, of integrating the ‘hard’ and ‘soft’ elements. At the most senior level, there was a well-developed and personal commitment to reconciling, integrating and balancing potentially polarised positions and ideas that mirrors the type of “deep learning” described earlier in this chapter. As the data from the rest of this study shows, however, within the multi-layered environment in which the FNP model is operationalised, a linear flow of influence – up and down – does not exist. Rather there

is a complex web of influences in dynamic interplay with one another. The commissioning of this research by the NU is a demonstration, however, of an interest in looking beneath the surface, of digging down, to better understand how to support the FNP system and beyond to maintain a balance between the potential polarities within the model.

Conclusion

In this chapter, the views and experiences of professionals about the organisational implementation of the FNP model have been presented and discussed. This has provided a 'practice-near' (Cooper, 2009) and 'behind the scenes' view of the way that the model is operationalised, and, by linking back to the previous chapters and the data from clients and family nurse clinical material, a rich and "thick" description (Geertz, 1973) of the work. The chapter points to a model which enlivens contrasting impressions and feelings, and to the complex psycho-social interplay between individual actors and the wider context – both locally and nationally.

The chapter points to how, in its prioritisation of fidelity to the model, FNP can be experienced as rigid in its boundaries, and, therefore, inflexible to the needs of those in most need, creating a sense of disappointment and envy within sibling services (Stokes, 1994). This is enlivened locally in terms of debates around who the programme is for – the most vulnerable, the "worried well", all teenage parents or just some. Within environments where resources are scarce, and in which family nurses are not engaged in strategic level influence and leadership roles, this can inhibit the holding and appreciation of a balanced position towards the 'hard' and 'soft' aspects of practice. This can lead to an over-reliance on the 'evidence-base', or a wish to reduce the emotional cost of the role in favour of seeing it primarily as a protocol-led programme of education – both of which are suggestive of organisational defences against anxiety. The NU has the potential to develop its role in leading on through the embedding of reflective practice internally and through the digestion of this research material, which provides opportunity for the appreciation of the complexity of its task.

Together, the three findings chapters evidence how the FNP model is sometimes idealised, creating pressure to 'get it right'. In the context of commissioning accountability, where power is skewed away from the FNP team, this can lead to a pressured environment. There are concerns about the emotional cost of the family nurse role and the interplay of this with the containment capacities of the FNP supervisor. The potential for greater peer networking and support is also prevalent across the data-set. Absent in the data is recognition of systemic or collective explanations for the obstacles encountered in the operationalisation of the model. Most significantly is the lack of discussion about the effects of the socio-political context in which young parents live, where stigma and discrimination are a common feature. The impacts of this on family nurses and the rest of the FNP system is taken up in the next chapter.

Chapter 7: Discussion

*Carry my pain on the right
Carry my joy on my left*
Bjork

Introduction

To begin with, I turn to the first two research questions: “what is the FNP model?”, and “what are the opportunities and obstacles to its operationalisation?”. In doing this, I also implicitly address the third research question – concerned with the role of psycho-social research methods – by demonstrating how this theoretical framework can be generatively applied in the context of an organisational study such as this.

To address the first question about the nature of the FNP model and how it is experienced and operationalised, I will consider the context within which the model exists, drawing on a range of sociological, psychoanalytic, social policy, cultural and systems theories. Specifically, I conceptualise the complexity of practice and policy in the area of teenage parents. Having done this, I go on to think about how this complexity plays out within the model, developing a set of meanings which illuminate the range of views and responses found within the fieldwork.

The findings chapters are structured according to participant type, to allow for separate reflection on the clinical and implementational functions and to ensure that the views and experiences of each group of participants are considered within the thesis. Here, however, I move towards thinking about the data as a ‘whole’ rather than delineating views according to their participant type. I am mindful that in doing this, client voice may become lost - especially as there was less divergence within this aspect of the data. It is important that this does not happen, particularly because this apparent homogeneity could be partly down to the challenges of researching critical or dissenting client voices in an area where power dynamics are significantly at play (Levin, 2015). To avoid this, I begin this discussion with the experience of being a young mother or father. This will provide a solid base on which to build the later

conceptualisation of the FNP model, which draws empirically on the perspectives of both those who 'receive' and those who 'deliver' services. The discussion considers how FNP members – 'nurses', 'teenagers' 'supervisors', 'commissioners' - occupy different positions according to their social constructions and the complex ethical and power dynamics which are played out during their enactment.

Paradoxes and Binaries - in search of a 'golden-thread'

A psycho-social, qualitative exploration of a phenomenon such as the FNP model - enacted as it is in diverse political and cultural settings - was never going to deliver a singular, one-dimensional answer. However, within my initial proposal, I had entertained the notion that the research might reveal the FNP model's 'golden thread'. This was conceived as a congruity running through the organisation which, it was hypothesised, might be apparent within a broadly consistent approach to, and prioritisation of, interpersonal relationships.

Whilst it is true that interpersonal relationships at every level of the organisation featured significantly within the data, in hindsight my initial ideas seem somewhat narrow. The 'golden-thread' now seems to be more complex and diverse than the one I had in mind at the outset, necessitating a much-expanded formulation. I now contend that the FNP model is a pluralistic, complex phenomenon, within which paradoxes, binaries and tensions are played out and give rise to diverse responses and reactions. This way of thinking about the model, I will argue, supports an expansive exploration that benefits from 'digging down' into FNP's primary task to inform new ways of 'scaling up', enabling a deeper appreciation of the task across the FNP system. I will argue that it is possible that although paradox may be an inherent feature of the FNP model, this can become either an obstacle or an opportunity, depending on the capacity, within a particular context, for its toleration.

By way of definition, I use the term paradox to describe how ideas, concepts, practices or feelings, which seem at odds with each other, are nonetheless in some way dependent upon each other or coupled in dynamic tension (Rappaport, 1981).

Binaries, on the other hand, could be thought of as when related elements, which seem in opposition to each other become polarised (Vince and Broussine, 1996). Sometimes this results in rivalries and competitiveness between the polarised elements – thought of a ‘splitting’ - such that integration is problematic or impossible to bear. Whilst paradoxes can be thought of therefore as ‘both/and’, binaries are ‘either/or’. I am influenced in this thinking by the psychoanalytic conceptualisation of the depressive position, in which the polarities of ‘paranoid’ or ‘schizoid’ positions are integrated within the mind of a baby, leading to the acceptance of a mother as embodying both the ‘good’ and the ‘bad’ within her. Following this, I hold that taking up a ‘both/and’ position is preferable to one which is ‘either/or’ if healthy organisational functioning is the goal. Both/and is less defended and more open to a multiple, complex ‘reality’. As I will demonstrate, however, there are many reasons why taking up the depressive position within organisations becomes elusive, and binary positions seem necessary for psychic or organisational survival.

Paradoxes within contextual features of the FNP model

Over the life span of the FNP programme, clients and their babies undertake a range of psycho-social developmental tasks. These include: preparing for and giving birth or, for a baby, being born; learning to care for, or being, a new-born baby; becoming a mother or father; being an adolescent who is both dependant on parents/carers and taking on adult responsibilities (both familial and extra-familial); becoming the mother or father of a mobile, verbal toddler or becoming a young child with language and mobility. Whilst these are all human, everyday life-course events, their apparent ordinariness can belie their underlying complexity and association with paradoxical feelings and tensions. I contend that before we think about the paradoxes within the organisational task, it is necessary to think first about how they exist within the experiences of teenage parents. I hope to thicken (Geertz, 1973) understandings of the paradoxes within the FNP client task, which will illuminate the later discussion about the task of family nurses, supervisors and the FNP model as a whole.

As I focus on early human life where maternal care is a predominant feature, I will mostly refer to mothering, or 'the maternal' (following Hollway, 2006). This is not to say that fathers and other family members do not play very important roles but by way of responding to the overwhelmingly gendered nature of early caregiving. It is also to reflect the historically rooted and psycho-socially generated projections that young mothers are uniquely subject to and the way that these feature within the FNP model. However, I acknowledge that it is possible for anyone undertaking a 'maternal' role to be subject to the paradoxical features explored, and in this sense, include fathers in the idea of the maternal, as I use it here.

An underlying assumption running through this section is the existence of unconscious transference and countertransference processes. Within FNP terms, this is similar to the idea of parallel-processes discussed previously. The FNP model design assumes that relationships affect relationships, specifically when it comes to the ideas of modelling and containment. I will use this idea to consider how the psycho-social features of FNP client's lives might be replicated or mirrored within FNP's organisational system. Equally, as the discussion moves to think about the FNP model's features, I will consider how features of the professional environment are also cascaded throughout different system levels.

David Olds designed the FNP model to begin as early as possible in the life of a child. My analysis will similarly begin at the beginning, with a discussion of the conflicts, binaries and paradoxes that exist within the experience of birth.

Birth

The paradox entwined within birth is seen in the experience of labour and in the ways that women speak about it. Giving birth has historically been - and continues to be in some parts of the world - a dangerous process sometimes causing the death of the mother, who literally gives her life for her child. Although this is very rare in Western countries, death, or the possibility of it, hovers around in the narratives, processes and affect present during labour. Despite modern medicalised birthing practice, labour remains a unique human experience that, in very general terms, involves the

experience of extreme pain in the service of unparalleled reward – a new human life. Van der Gucht and Lewis (2015)’s research draws on this idea of labour as involving an intermingling of joy and pain. Their argument is not that pain in any simple way leads to joy. More profoundly, they point to the paradoxical nature of labour, described as “the sweetest pain” (Beigi *et al.*, cited in Van der Gucht and Lewis, 2015, p. 356) – a complex mixture of ‘positive’ and ‘negative’ feelings, disrupting the idea that labour related feelings can be fixed within either one of these categories.

Even at the most simplistic level, it is possible to say that being born and giving birth are everyday human happenings, which nevertheless evoke extreme, existential thoughts and feelings – involving potentially the simultaneous beginning and ending of life. Giving birth itself is a physiological process which, although it “encompasses intense physical, emotional, psychological and spiritual elements that may be critical to a woman’s experience of this major life event” (Lowe, 1996 cited in Van der Gucht and Lewis, 2015, p.1), is also treated as mundane. This paradox is played out, for example within the media, which provides a vehicle for the “circulation of affect” towards the establishment of “cultural congruence” (Shoesmith, 2016, p.11). For example, in the spring of 2019, the British media interviewed Shamima Begum, a British girl who left her London home aged 15 to marry an Islamic State soldier. Four years later and nine months pregnant, she was keen to come home. In a powerful revocation of the judgemental public gaze described by clients in this study, the world watched, as a BBC reporter told Begum that her citizenship was being revoked, denying her re-entry to the UK. Almost as an aside, the report mentioned that she is no longer pregnant, but has a two-day old baby.

I was struck by the uneventful and ‘off-stage’ nature of the reporting of her transition from pregnancy to motherhood, in such extreme contrast to the media’s adoring attention given to any royal baby’s birth. I was also struck by how Begum’s baby’s cry, hidden beneath her clothes, was the only signifier that something transformative had taken place. My point is, the fact that one birth is portrayed as extraordinary and another as hardly worth points to how much trouble we have finding a balanced way of thinking about this process. It is difficult, as Rose (2018) writes, to “acknowledge a

new birth as the event that it is, without immediately divesting the new-born of its humanity” (pp. 78-79) – because it is both cosmic and very ordinary. It is deep paradoxical in the way that it is both very ‘normal’ and also not ‘normal’ at all. Acknowledging this tension is challenging, and often there is splitting. By this I mean that birth is held privately and individually as a profound and precious experience but in our collective, public discourses it is downplayed: I remember for example my shock at being scorned at by an orderly on the maternity ward when in post-birth recovery I dared to ask if I could have both an apple *and* a yoghurt with my evening meal. It was a strong thud back down to earth, to realise that rather than falling at my feet in awe at what I had just performed, I was being mocked for presumptive greed. I felt transformed by the experience and utterly *not* the same as I was, but within the hospital discourse, it felt as if I was just another ordinary woman who needed putting in her place.

From a psycho-social perspective therefore, the fact that each FNP relationship takes place around the processes of birth means that the binary forces discussed here are inevitably present in the milieu of the model. Following birth is the experience of being, or caring for, a new baby, which is where I will turn to next.

Babies

From a Kleinian perspective, being a young baby is a stage of life when extreme feelings are prevalent (Klein, 1946). As I have already alluded to above, a young infant within an object-relations framework is thought to oscillate between feelings of love and hate – known as the paranoid-schizoid functioning. As they encounter feelings of extreme pleasure and extreme frustration, these are experienced as if they emanate from different ‘part-objects’ – the good ‘breast’ and the bad ‘breast’. As the baby’s mother, or maternal figure, contains (Bion, 1962) and metabolises/digests these feelings. They are then ‘given back’ to the baby in ways that are now easier for them to take in, through a process called ‘reverie’ (Bion, *ibid.*). Eventually, if all goes to plan, the baby emerges into a state where they can experience good and bad as co-existing within the same ‘object’ (Britton, 1992, p.38). This is called the depressive position,

although of course it is never as linear as described, and continues as a process throughout life.

Elsewhere I have drawn on this process as a metaphor for thinking about organisational and social processes. Here however, I wish to draw attention to how the FNP model is focused on developing supportive relationships with mothers as they care for babies who are experiencing strong opposing feelings. Reflecting on this, Hollway (2006) writes that:

There is a period in children's lives (of variable length depending on historical and cultural factors in the construction of children) when their ruthless narcissistic demands place terrible strain on mothers, as, in this relationship, they are getting no consideration whatsoever. To bear this is a development challenge for anyone. (p. 68)

By the time an FNP client graduates, she, her child, and to varying degrees - depending on her emotional availability – her family nurse, will have experienced this challenging process. I saw evidence of this within the data, for example in the nurse who spoke about coming out of the 'baby fog' herself, when her client's baby hit the 6 months stage, showing a deep level of connection with the family's complex emotional work; or the mother who spoke about how her toddler comforted her when she coughed, showing that he had introjected her capacity to care for him, into an ability to now care for her (Waddell, 1998). That the FNP model wades in, as it were, at a time of life characterised by extreme states of mind and seeks to enable the containing function of parents in this process, further underlies my thesis that the presence of tensions and polarities are an inevitable feature of this model.

Rising to the challenge of containing the feelings of a new baby seems to give rise to yet another of the paradoxes surrounds this stage of life, namely the silence around what it is 'really' like. The Christmas carol *Away in Manger* contains the infamous line "no crying he makes" to describe the ultimate well-behaved baby Jesus. But whilst we 'know' that all babies cry and wake in the night, and we know that without sleep adults struggle to function and become low; discourses about how difficult and painful and depressing this is over a prolonged period are largely overtaken by the idea that little

babies are cute, can be dressed up and cuddled, and with the right feeding pattern, can be 'managed' into a 'routine'. Our defensive societal narrative is that babies can be 'easy' (as in, "is she an easy-baby?"), that they are 'blank pages' and of course, everybody loves them. One of the few times this narrative is undermined, ironically, is when it seems to be too seductive to some 'at risk' teenagers. When this happens, corrective measures are used in the guise of giving them responsibility for robot babies, almost as a tacit acknowledgement that we have failed to collectively tell the truth about what it is like to be a mother, and that this requires an equally disturbing, fantastical response which is to say that it is a bit like looking after a mechanical doll. This feels like a desperately individualist response to fixing our collective need to act as if babies are not hard to look after, whilst also knowing that they are. As a result, the harder, painful, confusing feelings are hidden and occupy a private, shameful place. It is therefore to maternal ambivalence as another contextual theme that I turn next.

Being a mother/maternal

Ambivalence

The fact that mothers, and indeed fathers might have mixed feelings and experiences about parenting seems to be both universally known and universally denied within Western culture. So, whilst we allow the odd risqué sitcom such as *Catastrophe* (Channel 4) or *Motherland* (BBC) to furtively 'lift the lid' on how (middle-class) parents 'really feel', overall these narratives are off-limits, with the darkest feelings perhaps hidden even from ourselves. Therefore, although it is hard to imagine a parent who does not experience their role as simultaneously a blessing and a burden, it is rare to find empirical research or popular narratives that examine, explore or present parenting from this depressive position.

Psycho-social and feminist theory provide frameworks for thinking about both the existence of this paradox and the oppressive perils of its denial. Hollway (2006), for example, discusses how difficult it is to access what she calls the "ordinary hate" of motherhood, alongside an assertion of how being able to integrate this with loving thoughts, can lead to ambivalence which is associated with 'reality'. This is a reality, however, which is surely much harder to face in the context of being the recipients of

so much structurally mediated hostility, as many teenage parents are. Nevertheless, within my fieldwork, there were instances of this type of interchange between family nurses and clients. For example, the father who spoke about how profoundly important it was for him that his family nurse had created space for him to talk about what he had lost through becoming a father. He said it had led to him being able to stay with his partner and jointly care for her and their baby. There was something very powerful about the 'permission' that he felt he had been given by his family nurse to say what he felt, and her acceptance of his conflicting thoughts and feelings, which he felt had built his confidence in his role.

These findings echo the views of the participants of Aparicio *et al.*'s (2018) study of Looked After teenage parents who also discussed how their ambivalent start to becoming mothers had given way to feeling like they 'came into their own'. Whilst the study found that the mothers developed into their roles over time in ways that echoed that of older women, they were also doing this in the context of unstable living arrangements, facing up to broken relationships with their own mothers and worrying about their children being removed – much like many of the participants in my study. However, despite this, another paradox which is often associated with parenting and might be particularly so in the experience of teenage parents is a sense that over time, painful and difficult experiences are looked on as having contributed to something new and better than what was there before.

Within my data certainly, graduated clients, in particular, expressed the view that they had overcome adversity and that this overcoming had contributed to their sense of self-efficacy. This created a profound and paradoxical perspective on past experiences, one where there was something close to gratitude for the way that difficult experiences had, in hindsight, added richness and meaning to life. Whilst this might be something that many people can relate to, particularly when it comes to parenting, I suggest that this is potentially heightened for younger parents, because of the hostile environment in which many bring up their babies. This would be congruent with the studies which point to the positive feelings that teenage parents have about being parents, in the context of considerable adversity (SmithBattle, 2018).

Cultural symbolic expectations

Being able to access and own ambivalence about the maternal role is at odds, I would suggest, with narratives within our culture which position mothers within binaries. Occupying a 'realistic' or 'depressive position' as a mother of any age, is, as feminist thinkers point out, fraught with under the surface, deeply felt hazards:

Feminine fertility and pregnancy not only continue to fascinate our collective imagination, but also serve as sanctuary for the sacred...Today motherhood is imbued with what has survived of *religious feeling* (Kristeva, 2005 cited in Levy, 2013, p. 21).

I would contend that in contemporary culture however, with the exception of the Virgin Mary, motherhood-as-sanctuary is disrupted by the body of a teenage mother. By refusing to comply with idealised expectations, her very existence becomes a threat to deeply held fantasies about a mother's place in society, her role. Instead of worship, she receives hate. Indeed, within Cartesian dualistic thinking, "motherhood has long been a favourite target with the good/bad mother dichotomy a key feature of maternal discourse" (Wilson and Huntington, 2006, p. 61). Building on previous discussions of the cultural positioning of younger mothers, it is pertinent here to develop the conceptualisation of motherhood/'the maternal' and its complex symbolic and cultural position within the collective unconscious, as characterised by paradox. Given that family nurses model maternal behaviour - sometimes even physically enacting this via demonstration with prosthetic babies - it is important to consider how they, like their clients, might imbibe unconscious cultural expectations about the role. If part of the family-nurse task is to work out what it means to be maternal/paternal with a client, then an awareness of the cultural and social forces which seek to fix this within binaries is key.

The destructive and oppressive nature of binary narratives around mothering surely helps to explain why Donald Winnicott's famous 'good enough mother' (1971) has had such traction. As a tacit acknowledgement of the paranoid schizoid tendencies in this area, it points to our need for a depressive position mantra to help us to weather the storm and avoid splitting. As Rose (2018) highlights, there are many cultural tropes which play into these divisive processes, such as the way that within Western culture

mothers are either worshipped or vilified – characterised by Freud's (1912) classic Madonna/Whore dichotomy. This creates a pressured climate of high expectation and high punishment for anyone seen to transgress, often played out in the media where complex psycho-social projections and defences can be enacted as if they are 'natural' processes and go therefore unchallenged (Shoesmith, 2016).

Delving into this further, Hollway (2006) explores how women's actual lack of power is nevertheless juxtaposed by their psychic power within the trope of the omnipotent mother, about whom there are paranoid fears of dependency. This in turn evokes both the denigration and idealisation of mothers – binaries which are both enacted as a defence against the threat of a mother's power. Rose (2018) in her book *Mothers: Essays on Love and Cruelty* writes:

The idea of maternal virtue is a myth that serves no one, certainly not mothers, nor the world whose redemption it is meant to serve. Or put it more simply, no woman who has ever been a mother can believe for a second that she is only ever nice (virtue *and* terror both). (p. 83)

In the light of such challenges to acknowledging ambivalence around motherhood and fatherhood in general, there is once again an intensifying of this paradox when applied to teenage parents. As FNP clients traverse the delicate terrain of talking honestly about maternal and paternal 'virtue' and 'terror', they know that they are *automatically* seen – by policy, the public and health professionals – as deficient (SmithBattle, 2018; Arai 2009; *The Teenage Pregnancy Myth*, 2012).

I would argue that this makes taking up a position of healthy ambivalence, as advocated by Hollway (2006) above, all the more problematic. For young parents, being able to own and declare positive feelings about their mothering or fathering can – strange though it might sound – represent social and political deviance. At the same time, it can also represent complicity with cultural expectations about the jubilation that they are 'supposed' to feel. Conversely, when teenage parents speak about their difficult experiences, they may be reinforcing or internalising the negative projections of others, within which any positive narratives might be enacted as a defensive

‘shoring up’ process, rather than something ‘real’ and ‘depressive’. Overlaying this are legitimate fears that admissions of ambivalence will be taken as an issue for concern by professionals and lead to safeguarding intervention (Featherstone and Broadhurst, 2003).

Looking at it this way, we see how complex it is for a family nurse to encourage ‘terror’ talk or ‘self-efficacy’ in clients. Highlighting the intersecting contextual psycho-social features reveals what is at stake when family nurses, young parents and their babies seek to form relationships characterised by honesty and dignity. This is a relationship taking place within social, psychological, political and cultural fields deeply imbued by unrealistic, deeply held ideas on what it means to be a mother/maternal. At very least, I hope that becoming *aware* of these features and how they expediate polarised and binaried thinking, will strengthen family nurses’ and clients’ capacity for having realistic conversations about their experiences of motherhood.

Intersubjectivity and individuality

Talking about first-time motherhood in general, rather than specifically the experience of adolescents, Hollway (2006) points to another paradoxical feature of this stage of life. She describes how mothers experience a transition from an individual to an intersubjective identity, which produces ‘ordinary’ (internal) conflict. Within this, mothers come face to face with the psychic challenge of choosing between their own needs and those of their baby (Baraister, 2009), brought about through the immediacy of the caring task, described vividly in Berry’s (2018) poem *The Republic of Motherhood* as “Feedingcleaninglovingfeeding” (p. 1).

On a more conceptual level, Hollway elaborates how the:

intersubjective space, beyond one's separate self but continuously modifying it and the other,[helps to] keep in view both the intersubjectivity of the mother-infant couple (and its later manifestations in that and other relationships) and the mother's (and later also the child's) individuality consisting of different sometimes opposing wishes and characteristics. The resulting dynamic tension in any caring relationship is not only the source of conflict, frustration and occasional breakdown, but also a creative source of change and the crucible for the capacity to care. (2006, p. 82)

Hollway draws attention to how this understanding of maternal identity challenges Enlightenment ideas of the autonomous subject. This echoes the literature presented earlier from a critical social policy perspective, that questions the exclusive promotion of narrowly defined neoliberal conceptualisations of individual choice and self-actualisation. Whilst, as I noted, Hollway is speaking about motherhood in general, I would argue again that this complex, conflicting process of developing intersubjectivity is heightened within the experience of a teenage mother. Psycho-social understandings of adolescents describe the process of 'subjectivation' (Briggs and Hingley-Jones, 2013) – a complex internal and external negotiation involving separation-individuation, as a child moves away from their parents and develops an independent sense of self. This is characterised by "oscillating states of mind in an emotional field" (p. 64, *ibid.*), as teenagers begin to understand themselves in the social world of peers and wider society. Young parents, the clients of family nurses, therefore, are navigating a highly complex process of identity formation. This involves simultaneously separating and merging, as they undergo both of the processes discussed above at once, thus raising the stakes further.

I call to mind an observation of a home visit with a family nurse in which she and I became bystanders in a conflict between three tenants of a mother and baby home. It had all the hallmarks of an 'ordinary' teenage fall out – two against one, paranoid accusations and defences. For me, the poignancy lay in the fact that the apparent accusations being defended against had a far more adult theme than the 'ordinary' topics of teenage conflict. They centred on accusations about apparent poor parenting and lack of domestic skill. Once things had calmed down and the nurse and I were

walking away, I began to imagine what it must be like to experience teenage feelings - with all their turmoil and angst - *at the same time* as new mother feelings - with all their vulnerability and confusion. It was a horrifying, overwhelming thought. I felt a wave of empathy towards the clients I had just met, and fascination at how they coped with regulating their own and their baby's "oscillating states of mind" within so many "emotional fields" and a context of multiple and conflicting expectations.

Summary

I have described the contextual paradoxes and binaries which exist in the lives of teenage parents, not to add weight to a narrative which says that teenagers should not be parents. Rather, I have intended to demonstrate the multi-layered, complex psycho-social experiences of a teenage parent. This lays the foundation for the discussion to come about the paradoxes within the FNP model, which are at least partly explained by the fact that its primary means of delivery is through intimate, long-term relationships with people who are negotiating conflicting, high-stake, paradoxical forces.

I believe that the FNP model will inevitably be influenced by the processes experienced by its clients, in ways which it is impossible to trace linearly. This does not make them any less worthy of attention and acknowledgement and arguably makes them more so. In keeping with the paradoxical theme, during the fieldwork, along with feeling overwhelmed and scared I also felt respect and awe towards parents who were demonstrably *not* imploding under such immense pressure. This helped me to understand what family nurses mean when they talk about the privilege of their role. Some of this must surely come from an intuitive appreciation of the lives of their clients who are 'coming into their own', despite everything that I have laid out here. In seeking to explore the context of the FNP model in this way, I hope to add to a broader, less simplistic narrative around the 'problem' of teenage parenting, which locates the difficulty of their task within a psycho-social narrative of binaries, expectations and paradoxes. In the next section, I will turn my attention to the organisational task and trace how these are played out within the delivery and conceptualisation of the FNP model.

Paradoxes within organisational features of the FNP model

I will now consider how paradoxes manifest themselves within the FNP model, providing a psycho-socially framed explanation for their existence and exploring those factors which support or hinder members and stakeholders taking a both/and 'depressive position' in relation to the FNP model. My starting place is to draw on the concept of the 'primary task' from the field of psychoanalytically informed group relations and organisational consultancy.

Primary task/s

The findings chapters revealed how there is broad agreement about the nature of the FNP model at a descriptive level and yet differences in understandings, practice and experiences. I deploy primary task thinking to this issue, to generate meaning and understanding about how this divergence has arisen. Developed by Miller and Rice (1967), it is a way of exploring in-depth the nature of an organisation's goals (Armstrong and Rustin, 2015). There is a recognition within the concept that an organisation's primary task might reveal differences between what is intended and what is experienced or practiced. This is especially likely, I would argue, within a system like FNPs that is operationalised within multiple social, political and local contexts. The fieldwork for this research spanned four FNP sites and the FNP NU. It included observations and interview with clients, clients' family members, family nurses, FNP supervisors, clinical and safeguarding supervisors, commissioners and a range of related professionals from health and social care. Given this diversity, it is no surprise that there might not be one unified interpretation of the FNP model. There are therefore no moral values attached with noticing paradoxical divergences within the primary task, but rather an opportunity for a renewed appreciation for the complexity of the work and opportunities for enhanced support mechanisms to emerge.

Lawrence (1985) sharpened the analytic tool that is primary task analysis by directing attention towards the layers of meaning within organisational activity, differentiating between a 'normative', 'existential' and 'phenomenal' primary task:

The normative is what members of an organisation feel they ought to be doing, under the direction of authority; the existential task is what they believe they are doing; and the phenomenal is what is hypothesized that they are doing, perhaps outside their conscious awareness. These distinctions are analytically useful in getting to grips with belief, fantasy, and reality in the behaviour of organizations and their members. (Armstrong and Rustin, 2015 p.12-13)

Therefore, whilst the data reveals a broad consensus around FNP's normative task - though there were some exceptions to this, as I discuss below – it is at the phenomenological and existential primary task levels that the starkest differences can be seen, in particular around how professional respondents viewed the FNP model. It is striking for example that whilst some professionals viewed the FNP model as flexible, others viewed it as rigid; and whilst some saw it as bringing about containment others associated it with being overwhelmed. It was also the case that these contrasts were manifest within individual research respondents who, for example, said that they experienced the FNP model as both a privilege and also very painful to deliver. Another example of this was the contrast between how the model was described. It was, depending on the audience, simply giving someone a helping hand, much like a kind family member; or, activating transformative societal change which reverses the intergenerational cycle of poverty and child neglect. Were these two accounts of the family nurse role describing the same phenomenon? What could account for the divergences between them?

In this next section therefore, I will tease out these polarised descriptions by firstly looking at the conceptualisation of the welfare subject within the FNP model. I will then consider the conceptualisation of the 'problem' that the model is seeking to address. Finally, I will turn my attention to the practice of addressing the 'problem', and in so doing seek to illuminate the complexity of the primary task/s and the paradoxes and binaries that are played out within it.

Conceptualisations of the welfare subject

Within the discussion of the social policy arena relating to teenage parents, I referenced the work of Schneider and Ingram (1993) (Figure 5), which has been usefully applied by Arai (2009) to draw attention to the shifting social construction of the ‘problem’ of teenage mothers. She explains how social policy over the last two to three decades has seen a shift from positioning teenage mothers (and, possibly in a less straightforward sense young fathers also) from ‘deviant’ to ‘dependant’. She also draws attention to how this shift, though it might represent a more sympathetic view of teenage parents, does nothing to change their social, cultural or political power – under both scenarios they remain a manifestly disempowered group of people.

Social Constructions and Political Power: Types of Target Populations

		Constructions	
		Positive	Negative
Power	Strong	Advantaged The elderly Business Veterans Scientists	Contenders The rich Big unions Minorities Cultural elites Moral majority
	Weak	Dependents Children Mothers Disabled	Deviants Criminals Drug addicts Communists Flag burners Gangs

Figure 5: Social Construction Matrix (Schneider and Ingram, 1993, cited in Arai, 2009, p. 133)

This is a helpful framework for the consideration of how teenage parents are constructed within the FNP model – for example does it cast them as ‘deviant’, ‘dependant’ or something else? How are these constructions manifested?

The data certainly reveals that within the FNP model, teenage parents are celebrated. At both the national and local levels FNP staff identified strongly with the idea that they approach teenage parents with respect and humility, as experts in their own lives. Several nurses referenced the somewhat radical idea that the FNP model enabled

them to show love towards clients. Consistently, I heard stories from clients and nurses about the way that nurses ‘believed in’ clients, often ‘against the odds’ – i.e. compared to the views of other professionals. I observed how the FNP model is focused on building honest, caring and genuine relationships in which family nurses act towards their clients as if they are indeed capable, competent parents. This is a construction of teenage parents which is a stage beyond ‘dependency’ (as seen in Figure 5) and is better described as positioning the welfare subject as ‘dignified’ and even ‘desired’, along with an acknowledgement of how they are also discriminated against.

This is not a straightforward construction however, because whilst the FNP client is, indeed, positioned in this way, there are also other constructions at play. Taking the FNP vision statement “Changing the world, one baby at a time” and teasing this out provides a window into thinking about other, less obvious but nonetheless powerful constructions. The vision focuses on global change. Efforts are directed towards optimising the early parenting experiences of a baby, in the belief that this will lead to both a parent and a child with a range of better life outcomes – presumably including a child who grows up less likely to become a teenage parent in future. The idea of parallel processes – one process affecting another, and intergenerational cycles run through this idea. Within this conceptualisation, the best future is one where there are no more teenage parents. This is a tacit declaration that teenage parents are likely to have been parented ‘sub-optimally’, and that they are therefore at risk of also parenting sub-optimally. Within this construction, a teenage mother is ‘deficient’, because her ‘natural’ parenting, i.e. without FNP intervention, is viewed necessarily in need of ‘changing’ from something to something else. Alongside this deficient construction, she is also somewhat ‘dependant’ on FNP to be able to parent ‘optimally’, whilst also understood to be both socially and familially deprived.

We can see, therefore, that the FNP model embodies a paradoxical welfare subject, who is manifestly celebrated and, in complex, subtle and unintended ways, defamed. Manifestations of the celebrated subject are very visible within the model, particularly in the presence of clients. In contrast, the defamed subject is much less visible and rarely comes into conscious awareness concerning an actual teenage mother, although

in my research interestingly fathers were more readily characterised in these terms, probably due to their absence. I am not suggesting that a 'defaming' construction, were it to be verbalised about an actual client, would be anything more controversial than expressing a mixture of pity and regret that parenthood has come about at this early stage of their life. However, even something as seemingly benign as this - which is probably fairly close to how many people view teenage pregnancy, and a taken-for-granted position within contemporary social policy (SmithBattle, 2018) - is thrown into relief by actual teenage parents who, if they 'construct' themselves at all, I would suggest, are manifestly not doing so within the same binary terms. This raises questions about ethical practice and the possibility of working to minimise rather than reinforce disempowering constructions. This is particularly so, when as is the case here, defaming constructions are tacitly held 'beneath the surface' and might coalesce with dominant social, cultural and political views, which position teenage parenting as unambiguously negative.

The existence of this paradox is a kind of organisational "unthought known" (Bollas, 1987), which cannot be countenanced because it risks undermining the family-nurse relationship. To see it, therefore, it is necessary to look at the places where contrasting constructions come into conflict with each other. In my research, this seemed to be apparent when someone felt discomfort, frustration, guilt or a general sense of ethical unease about the work. Here is an example of a family nurse, who during a reflective supervision session, is speaking of how she feels conflicted about whether to encourage a particular mother towards employment, because of the effect it seemed to have had on her ability to hold a dual focus on her own needs and on that of her baby (the intersubjectivity and subjectivity discussed above). My observation notes read:

The nurse said that she thought the FNP programme encourages them to get mothers into work, but sometimes this is not good for the baby. She said she's seen a similar thing happen with a mother who switches her attention outside the home and seems to forget her baby. She said, "it feels like I'm taking her out of the home, and then having to hold her". She stretched out her arm and then cupped it to show an outstretched holding position.

Like all the other nurses in the site, in general, this nurse expressed unwavering support for the idea that a second baby was "the last thing she needs" and was aligned with FNP's goals of supporting clients to take up education or employment instead. However, in this instance, she is not sure. What if a mother – this mother - would benefit from a different route, wishing, like many older parents, to have their children closer together? In the process of strongly discouraging parents from becoming pregnant again, we see the celebrated welfare subject – the mother who *can* – coming up against the denigrated subject – the mother who *can't/shouldn't/must not* (at least for now). Indeed, FNP is sometimes regarded as being a 'victim of its own success' (Mason, 2016) when its efforts at increasing maternal self-efficacy lead 'ironically' to greater numbers of babies born to its clients– as raised by the First Steps report (Robling *et al.*, 2015). Within this construction however, the 'injury' caused to FNP (as the 'victim') is a child, the child of a teenage mother, born because its mother is, within this logic, 'too confident' of her mother abilities. This is clearly an ethically problematic position to hold.

'Holding', is the metaphor used by the nurse in the extract quoted above. At a deeper level than she perhaps realises, she is talking about what it is like to 'hold' a meaningful, respectful relationship with a welfare subject who is constructed in ways that shift and slip from her grasp. Woven within this is what she is 'holding' on behalf of a system wherein there are such paradoxical constructions. She would like to encourage this mother to stay at home and focus on her baby, but this would risk encouraging her to have more babies, and babies, if they are born to teenage parents are surely problematic, aren't they? Therefore, she feels that she must encourage her to be both the best mother she can be (with the baby she has), whilst making sure that she does not identify with this role so much that she makes a career out of it.

Returning to the client being discussed in the extract above, and her nurse, wondering about how to guide her, it is also important to consider that she is likely to have experienced years of negative messaging about her skills and abilities within educational settings (Alldred and David, 2010). This means that any positive affirmation of her mothering abilities from the family nurse is likely to carry significant weight. In this way therefore, we can see that the positioning of the denigrated or celebrated subject is mediated by social and cultural expectations, in which a teenage mother is viewed one hand neoliberally as an economically active citizen; and other, through a highly gendered framework. This means that she is seen as both unquestionably responsible for meeting all of her baby's needs; whilst equally unquestionably, expected to prioritise financial independence from the state, even when these goals seem incompatible or unavailable (Edwards *et al.* 2015).

Building on Schneider and Ingram (1993) with Arai's (2009) work, Figure 6 shows the different ways in which teenager mothers (and to a lesser extent fathers) are constructed within the FNP model. She moves across the spectrum, from dependent, to deficient/deprived, to dignified/desired and back again. As I have highlighted above, overlaying the constructions are social and cultural expectations such as gender norms or the effects of a dominant neoliberal society. Building on Arai's (*ibid.*) argument relating to the powerlessness of the deviant and dependent subjects, I would argue that the deficient/deprived subject also lacks power (i.e. she is not thought capable of deciding the timing of her subsequent children). Although the dignified/desired subject has the potential for being afforded more power, this is diminished by the fact that the constructions are so 'slippery' and often beyond conscious awareness.

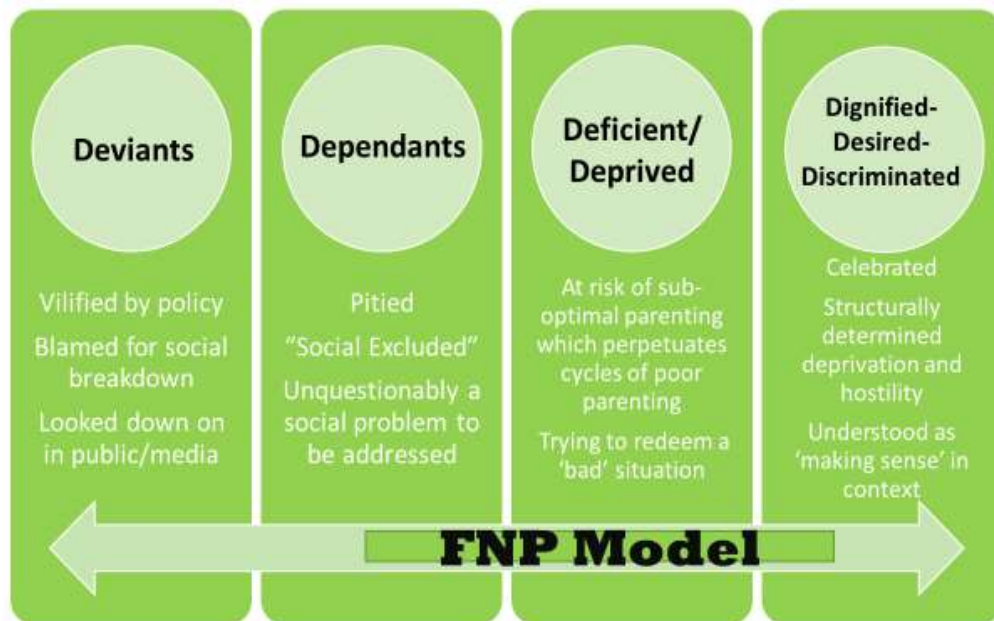


Figure 6: The social construction of a teenage parent within the FNP model

An example of how empowering constructions are diminished by less empowering construction can be seen in the way that the FNP model is predicated on clients voluntarily choosing whether to take up the service. On the one hand, this is in line with the idea of a dignified subject, who has the freedom to decide her own future. However, this is undermined by the effect of other disempowering constructions already at play within her context - and as has been shown, also reinforced within the model itself - which serve to evacuate it of its intended effect. This is illustrated below in an extract from a conversation with a family nurse about this aspect of the model:

You ask them what they want out of the programme or what they want out of their life. I am the first person that's ever asked them what they want, they've always been told, you know. They've been told at school so that's why they leave, they're told by their parents so that's why they run away so I'm phoning them and asking them if they want a programme. They're not going to say yes!

This nurse's argument is that the choice she is offering has little meaning to many teenagers, because of the context in which they are already so incredibly disempowered. Similarly, stakeholders expressed their concern that the relational aspects of the model conflicted with the reality of young people's lives, who had little understanding of meaningful helping adults relationships. It

led them to consider the model naïve because of its attempt to construct an empowered subject without providing her with the means of becoming one. The conflicts between differently constructed subjects can also be seen in the worries nurses had about the model seeming inhumane and cruel in the way that it applied the eligibility criteria. Within these accounts there was frustration, and sometimes guilt, at the idea that while FNP might be reaching towards a construction of an empowered welfare subject, the wider context continued to disempower her. Although FNP nurses worked hard to overcome this, it was impossible - working on an individual level – to fully manifest the dignified construction, because of the way that teenage mothers and fathers are positioned in wider society as dependant or deviant.

I contend therefore, that the shifting construction of the welfare subject at the heart of the model means that what family nurses think they are doing – their phenomenological primary task – is revealed as highly complex, and at times hard to ‘hold’. In the next section, I will consider the implications of this for the ‘problem’ that the FNP model seeks to address.

Formulating the ‘problem’

If the construction of the welfare subject within the FNP model is liable to shift, then there are also corresponding complexities within the formulation of the ‘problem’ it is seeking to address. As mentioned, I was struck by how descriptions of the FNP task changed according to context. For example, within professional contexts, it was common to hear it said that FNP addresses the problem of inter-generational cycles of poverty and poor parenting – which, as I have elaborated, is in line with its vision statement. In contrast, when nurses were talking to clients, different formulations of their task were at play. I heard nurses describe, for example, how they were there to provide support so that the person in question could be the best mother/father they can be – the tacitly communicated problem, in this context, framed as ‘parenting can be difficult’. This implies something subtly different in focus from the idea of reversing sub-optimal parenting patterns - or any more colloquial version of this.

Perhaps one explanation for this can be found within the title of this thesis. ‘Digging down’ and ‘scaling up’ reflect FNP’s interest in working at both ends of the spectrum of scale. The FNP model draws on whole-population, large scale, public health narratives to formulate the ‘problem’ it seeks to address. However, it uses individualised, private, home-based, relational methods, enacted through intimate clinical nursing care to achieve them. Formulations which make sense within the former context, therefore, are thrown into relief by the latter. Working at the boundary between clients’ individual private lives and abstract social policy, family nurses are tasked on behalf of the organisation with holding together the extreme ends of the spectrum of scale – the general with the particular. As with the ‘holding’ activity that family nurses undertake in relation to the subject of the model, this is morally and ethically complex. It is not surprising therefore, that nurses find themselves presenting different formulations of what the problem is and what they are there to do, according to whom they are speaking. They may well at one level subscribe to the discourse of intergenerational change, but at the same time, when they sit in a client’s home, they do not tell her that they are there to mitigate the effects of her mother’s poor parenting, or anything even close to this. Perhaps this is because, as White, Hall and Peckover (2009) argue, professionals – and, I would contend, clients – are interpretive beings with their own ontologies, resisting singular thinking, because this fails to contain:

the glare of lives in the living, constrain the locally strategic practices of human agents, or muffle the noise from both in the swampy lowlands of practice. (p.1215)

The experiences of clients and family nurses, in the “swampy lowlands of practice” invite us to consider the nature of the divergence between how FNP’s task is formulated in different contexts, and what it means to try to enact a model which seeks to bring together the general and the particular.

Another helpful way to think about this is in relation to the idea of accountability. Across the systems within which the FNP model operates, there are multiple and complex webs of accountability at play, which operate at the various ends of the spectrum of scale. Within a precarious and competitive environment, one of the

dominant threads is a sense of accountability for ensuring commissioners continue to allocate funds to the service – which could be thought of as located at the more ‘general’ end of the scale. The threat that this wields is not hypothetical, indeed in the course of this study, one of the research sites was decommissioned. Crossing over with this thread is family nurses’ strong sense of accountability in relation to caring for, and about (Hollway, 2006), their clients – with whom they form close and even loving relationships, so much so that clients often see them as the only professional (or even person) they can trust. This form of accountability sits at the ‘particular’ end of the scale. However, back at the general end of the scale is another thread which relates to family nurses’ sense of accountability to the FNP ideal of ‘making a difference’ and which relates to the idea of intervening in intergenerational cycles. Family nurses and supervisors feel accountable for faithfully replicating the model as they were trained to practice and as it has been entrusted to them. Overlaying these threads are unequal power relations – for example, commissioners who hold much more power than those who use services, even if they are, in theory, there to serve their interests.

The power that family nurses and supervisors wield shifts according to their contexts, meaning that they can be caught within this complex web of multiple accountability structures, which operate across the general/abstract and the particular/personal. This can lead to ethically compromising choices such that one accountability structure (and the corresponding formulation of the ‘problem’) is prioritised over another. Nurses experienced, for example, the focus on data gathering, measuring and justifying their work as punitive and intrusive. One nurse reflected on the fact that sometimes she is not able to pursue particular topics of emotional distress with clients because of the distress she herself feels in relation to managing the demands of her work. The starkest example of conflicting accountability was seen in my observation of the multi-agency meeting with commissioners, described in the previous chapter. The rules at play within this social field (Bourdieu, 1990) seemed to dictate that this family nurse gave preference to her sense of accountability for the financial survival of the service

above that of preserving the confidentiality (and possibly dignity) of her client. A client's traumatic experiences were used to serve the purpose of securing financial stability – a sadly ironic reversal of the commissioning process. The fact that no one else seemed uncomfortable led me to conclude that the splitting and polarisation of discourses about the FNP task has become normalised, wherein 'performing FNP' in front of different audiences had become unavoidable, with the dignity of clients and ethics of nurses unnoticed collateral damage. Perhaps it is the case that when commissioners and other professionals are present, it becomes necessary to maximise narratives about FNP's task with generalised and impressive claims. In the presence of clients however, the 'problem' is downplayed and something much less grand and more 'ordinary' is talked about. The complex multiple layers of accountability to which nurses are subject to therefore, seems to make it difficult to achieve a depressive position at the local site level.

This is not to say that there is a great delusion going on, where nurses deliberately hide the 'true' purpose of the model. Nevertheless, there are unacknowledged tensions around how the 'problem', and therefore the purpose, of the family nurse role is conceived of, and understood. Neither is it the case that FNP clients were in denial that they needed assistance – wanting help is, after all, a prerequisite of the model. However, rather than talking about how family nurses were there to stop them from replicating intergenerational parental maltreatment, clients spoke about how they were there to reassure and encourage them, to work *with* them rather than to *change* them. Although some clients spoke about how their family nurse occasionally challenged them, in the main they believed their purpose was to give them someone to confide in, provide trustworthy information, show them the best ways of being with their babies and to provide humane, kind, relational comfort and relief in the face of the contextual hardships I have repeatedly outlined. Likewise, the data I gathered with the mothers of clients followed similar lines. Although one acknowledged that she wished she had had access to the information that her daughter gained via her family nurse - such as the importance of skin-to-skin contact with a newborn baby – they did not speak as if their daughter's pregnancy was something that had resulted from their

own poor parenting, which the nurse was there to rectify – disrupting the idea of inter-generational cycles of deprivation (McNulty, 2010).

There are, therefore, two broad narratives which emerge about the ‘problem’ which FNP is there to address: one focuses on the idea that the FNP model mitigates the potential deficiency within an individual mother’s parenting; the other on alleviating the effects of the contextual hardships which impact her mothering – a process which might include capitalising on the role of the father, for example. Within a complex accountability climate – where general and particular narratives are deployed and dictated by hidden and shifting structures of power – it is difficult to find a middle ground that holds both of these narratives together. This leads to a multifactorial ‘problem’, with correspondingly shifting phenomenological primary tasks, even when normatively speaking the task might appear the same. In the next section, I will turn my attention to the design features of the FNP model and hypothesise about alternative existential primary tasks which are generated from observation of family-nurse relationships.

The FNP model

Individualist lens

One of the design features of the FNP model is a commitment to the views and perspectives of teenage parents – indeed stakeholders spoke about how this aspect of the model represented a departure from a top-down medical model, for example having young parents on interview panels and attending annual meetings to give an account of their experiences. However, as I stated earlier, the FNP model was not designed in response to the expressed needs or interests of teenage parents. Rather, it was developed using a social policy lens to formulate the idea that teenage parents are at risk of reproducing poor parenting and thereby perpetuating poor outcomes for their children. It aims to reduce child maltreatment across a large population. Therefore, although the model draws on ecological theory, recognising that systems around an individual shape their choices, it is designed with considerable emphasis on

the role and responsibility that mothers have for the environment in which their children grow. Here is an example of this in a quote by David Olds:

There is a magic window during pregnancy... it's a time when the desire to be a good mother and raise a healthy, happy child creates motivation to overcome incredible obstacles including poverty, instability or abuse with the help of a well-trained nurse" (Nurse Family Partnership, 2019)

The possibility of 'motivating' clients through relationship to "make certain changes" – to quote an NU leader in this study, is a common idea within FNP. Indeed, the model draws on Motivational Interviewing – a cognitive behavioural communication method developed originally to enable people to live without addiction. In the light of the complex psycho-social factors I have outlined however, it seems questionable to consider that such 'incredible obstacles' might be overcome solely or even mostly by an individual psychological process of personal 'motivation'. The findings of this research about the many contextual and structural factors over which teenage parents have little control suggest something of an ethical imbalance in the emphasis on a mother's internal determination for a better future for her child. Drawing on the conceptualisations in Figure 6, this feature of the model seems to be underpinned by the idea of a 'deprived' and 'deficient' mother who is nevertheless 'determined' to be better than her upbringing.

This is not to say that family nurses explicitly hold mothers responsible for the poverty, instability or abuse they face - although it was occasionally the case that they seemed to hold clients' parents as responsible for these. Rather, I suggest that the model is designed *as if* a mother holds the (magical) keys to a place called 'overcoming', accessed via the quality of her maternal desire. The fact that this is enacted in the main via private conversations between a mother and her family nurse leads to a paradox wherein one of FNP's strengths – the individuated family-nurse relationships, might inadvertently re-enforce the idea that teenage parents, and their family nurses are responsible for their adversities. Likewise, there are also inherent ethical issues with the presumption that a teenage mother might be insufficiently motivated to be a 'better' parent than her mother was to her; that she may be insufficiently motivated to

prevent the disadvantage she has faced having an impact on her own mothering; and that this process requires behaviour change through a directive process to overcome her ambivalence therein. This process of expectations of individual relational processes is captured in its 'purest' form in Figure 7.

The FNP model draws on one-to-one processes to bring about change, with the supervisors, as discussed in the previous chapter, at the top of this chain. This is not to say that this is how the model is always practiced, but it is sometimes conceived, and therefore where some disjunction might arise in relation to its task. Seen in this stark way, it also helps to make sense of why supervisors and family nurses struggled with, and felt isolated in their task, and carried a personal sense of personal failure when anticipated 'results' were not forthcoming. As explored in the previous chapter, there are several contextual factors which impact on the supervisor's ability to provide containing supervision, including a competitive commissioning environment, austerity and wider organisational issues such as restructures. A less than containing supervisor, along with a dearth of local support services and a lack of understanding of FNP's role, can, in turn, inhibit the capacity of a family nurse to contain the anxieties of the clients she works with. At the same time, for teenage parents, the wider effects of the judgement, injustice and discrimination that they experience can, understandably, limit their capacity to manage their baby's feelings. However, in practice, these contextual factors are often missed in the conceptualisation of parallel-processes, whilst expectations of individuals are heightened, as Figure 7 shows. The reference to a baby's brain is included in brackets in the final hexagon, to reference the risk within individualised early years intervention models of placing a de-contextualised emphasis on neurobiological processes (Edwards *et al.* 2015) rather than, as I have been arguing, seeing the whole system within the wider social, political and cultural environment.

As the research evidenced however, there are opportunities for broader understandings of the model, which respond to a 'thick' description (Geertz, 1973) of teenage parents' lives, as I will discuss below.

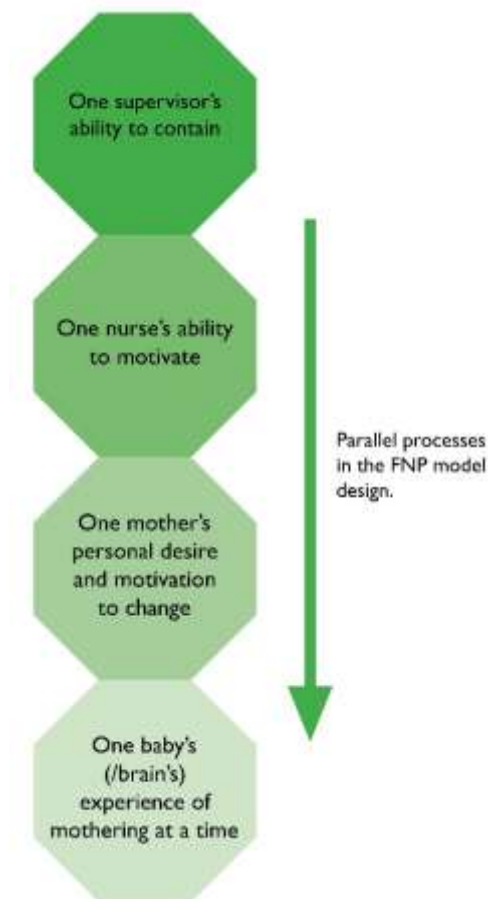


Figure 7: Individual processes of change in the FNP model

Growth and transformation

Family nurses may have a role in motivating some clients to change *from* one way of parenting *to* another, but an examination of practice and clients' views suggest that other broader tasks are being enacted. Some nurses spoke about how their core work involved being emotionally available for clients, implying a dynamic relational process is at play. Others spoke about what they offered was 'medicine', implying a more transactional process of imparting something so as to make someone 'better'. In their book *Protecting Children: a social model*, Featherstone *et al.* (2018) highlight how relational features on the one hand, and more technical or educative aspects on the other, are increasingly thought about separately from each other in efforts to measure the effectiveness of welfare approaches:

Having somewhere to go and someone to talk to are ubiquitous features of most 'interventions'. So, why is it that researchers persist in paring down 'interventions' so bound up in the communicative practices of people and so self-evidently laden with contingent social meanings and matters of relationship and trust, to a set of 'ingredients' ostensibly separable from their medium of transmission? (p.47)

Whilst there was confusion and polarisation about how to work with the model's programme - causing some nurses anxiety - almost all of the nurses in the study were enthusiastic about the potential of developing relationships over time with clients, even if they were less clear on the 'evidence' supporting this. Observations and interviews revealed that these allowed for complex psycho-social work to take place, which, I would argue is one of the 'existential' primary tasks of the FNP model. Whilst the model design emphasises a mother's motivation to change, I suggest that the task I more often observed would be better described as supporting growth and transitioning. Although some nurses were wedded to the idea of faithfully working through the programme material and others dispensed with it altogether, most seemed to provide clients with highly valuable relational experiences, which I suggest hold myriad privately held meanings for both themselves and their clients. Three of these that I saw during the analysis of interview material are 1) family nurse as a transitional object; 2) family nurse as a bridge; and 3) family nurse as a repository.

Taking these in turn, the first relates to the way that family nurses embodied or created for some families a psychological 'home'. Drawing on Winnicott's (1971) ideas about infant emotional development, the transitional object is the first 'not-me' possession which a young child symbolically attaches to which travels with them between their inside and outside worlds both symbolically and figuratively. Applying this to a family nurse, I observed how she seemed - for a particular parental couple living insecurely between two homes and within an insecure relationship themselves - to be something of a symbolic, 'not-me', object. By this I mean that she was an embodied fixed point, someone who literally and psychologically travelled with them between identities and spaces, creating stronger lines around their new family identity, in the context of considerable material insecurity.

The second idea – ‘family nurse as a bridge’ - refers to how family nurses supported clients to move between safe and hostile spaces, lending them social capital (Bourdieu, 1990) due to her middle-class professional identity. This was seen in numerous ways, such as the mother who described using her family nurse on the bus when she felt the negative gaze of others, or in stories of other mothers who described a growing sense of legitimacy and rightful place in the world which seemed to be at first borrowed from their family nurse and later owned for themselves. Not only do family nurses ‘carry’ clients into hostile spaces that they might be too wary to enter alone for fear of judgement, but they also bring ‘officialdom’ into their homes so that the ‘safe bridge’ can be traversed both ways. This provides some clients with a language and knowledge of how to conduct a helpful professional relationship and ameliorates the wider hostile environment.

Thirdly, ‘family nurse as repository’, refers to how some clients came to regard their family nurses as custodians of important memories, referencing the knowledge they held and drawing upon it. I was alerted to this in an interview that took place a while after a graduation, an extract of which is presented below with the client ‘J’ and the family nurse ‘H’:

- J: Do you remember, [name of family nurse], when my waters perforated?
- H: Oh, you were at, it was probably, it was quite a while because I kept on saying that, you know, that really you should be in there and being checked.
- J: Yeah, because they left me til I was at week 34.
- H: Yeah, 34, 36. They were born at 40 weeks, weren’t they, these two? Quite big babies, which is quite unusual, isn’t it?
- J: Yeah.
- H: And you delivered them both yourself, didn’t you?

This type of exchange may seem ordinary, but its poignancy lay in the fact that, under normal circumstance, this family nurse and client would not have this conversation. Effectively, their relationship had ended and was only being reconvened for the interview. I understood through this interview how family nurses hold – that word again – for clients, a vast store of their early parenthood memories. Who has literally

'been there' during a time of intense learning and change. Graduation represents, for a client, a loss of access to this embodied, psycho-social knowledge store, held within the family nurse's mind – the relational repository. Clients who are socially isolated may make more use of this aspect of the family nurse role, whilst for others, it may be more diluted within a wider network of family and friends.

Within every family-nurse relationship there, I would argue several layers of these existential meanings and tasks at play. For many, these are privately held, not always available to conscious awareness by either clients or family nurses. Sometimes nurses felt the need to 'annexe' particular meanings, naming them as successes to themselves, even if they might not have been recognised as such by those to whom they were accountable - as discussed earlier in relation to the idea of 'strange successes'. The meaning of what is 'going on' in family-nurse relationships can be obscured, I believe, by its 'ordinary' or mundane appearance and mitigated by the reflective capacities and self-efficacy of both client and nurse. Meanings like these grow very gradually over time and are not always recognised as part of the officially recognised task. They do, however, help explain the strength of feeling that clients and nurses hold for each other: these meanings are highly personal, dynamic, iterative and affect-laden.

In one of my favourite short stories, A.S. Byatt (1994) writes:

Any two people may be talking to each other, at any moment, in a civilised way about something trivial, or something, even, complex and delicate. And inside each of the two runs a kind of dark river of unconnected thoughts, of secret fear, or violence, or bliss, hoped-for or lost, which keeps pace with the flow of talk and is neither seen nor heard. And at times, one or both of the two will catch sight or sound of this movement, in himself, or herself, or, more rarely, in the other. And it is like the quick slip of a waterfall into a pool, like a drop into darkness. The pace changes, the weight of the air, though the talk may run smoothly onwards [...] (p. 120)

Her metaphor – the dark river – captures something of the complexity and mystery of human relationships. Coming to it again, I realise that I too have been drawn to metaphor to help explain what is 'going on' in family-nurse relationships. Perhaps this

is because relationships are also full of paradox. It is an understatement to say that they are a fundamental part of life – maybe *the* fundamental thing in life. As one of the NU participants in this study expressed: “Well, relationships are, are....everything, really!” At the same time, trying to describe them in a way that does justice to their depth and intricacy, and also appreciates the ‘whole’, is very hard to do. As psychoanalytic theory has shown us, there are so many layers, so many - often unknown and/or unknowable - possibilities for what is ‘going on’. I have found metaphor to be a helpful way of appreciating relational processes without diminishing their complexity. It could, I suggest, continue to be a generative method for FNP to use, to further understandings of relationships within the model in the future.

Conclusion

The structure and application of the FNP model contain complex paradoxes. These are reflective of both societal unease regarding childhood sexuality and unresolved tensions within public service delivery under NPM. Alongside this, FNP clients undergo paradoxical life events, in which they experience contradictory and conflicting psycho-social processes. The links between these two are complex but are surely not coincidental. The prevalence of binaries and polarisations, of the struggle for integration and balance, run through the data. These divergences point to the multiple complex factors which influence how the model is framed within its local and national accountability, ethical and socio-political boundaries. Following a psycho-social methodology in general, and primary task thinking in particular, has revealed layers of meaning which can be thought about, digested and acknowledged – a process which I hope will serve FNP well.

Starting from the perspective that “there is innate psychic pain inherent in all institutions [and] that the nature of the pain is specific to the primary task of the institutions” (Obholzer, 1989 in Cooper and Lees, 2015, p. 242), I intend to ameliorate some of the ‘psychic pain’ within FNP’s primary task around the difficulty of holding together concepts and ideas which feel ethically complex and polarised. My intention was not to argue that the FNP model is inconsistent or self-contradictory, but rather to

show that paradox is an inevitable part of teenage pregnancy work in particular, and contemporary human service organisation in general (Rappaport, 1981) in which there are multiple agendas and interests which are sometimes in tension with each other (Hoggett, 2006).

I have argued that the existence of complex paradoxes, tensions and polarities within this work makes finding an 'optimum' position of balance difficult. The FNP model and organisation exist within a wider context and these necessarily impact on the way that the model is delivered and practiced, leading in some instances to the overemphasis on the technical and confusion about the relational. I have argued that family nurses can become locked into feeling individually responsible for the lives of their clients whilst not being able to do much about them and that this is a demoralising and dangerous position for them to be in. I have also argued that an over-emphasis within the model on the role of the supervisor as the sole container, can have some unintended negative consequences on the containment available to a team. There is however scope within the model to balance out any implied blame and guilt that individualist models could inadvertently create, with solidarity around reducing the hostility and judgment experienced by young parents. Linked to this is the potential for ensuring that nurses share with supervisors leadership roles at the local level, due to the ameliorating, positive effects that this has on building collective ways of working and reducing pressure on individual roles.

Chapter 8: Implications – obstacles and opportunities

Introduction

This chapter presents the implications of my findings for policy, practice and academic research. In line with my methodology and the collaborative nature of the doctorate, the ideas presented here were discussed with FNP's NU in draft form during the analytic stages through verbal presentation and via email exchange. Their affirmative responses have validated my confidence that this research has produced rich new insight into the FNP model, which can be utilised in training and practice settings. I also believe that my learning about the use of psycho-social research methods for researching complex organisations will be of value to the wider academy.

Models of social work practice which apply ecological and systemic thinking have risen in prominence in recent years (e.g. Restorative Justice, Family Group Conferencing). These models, however, continue the dominant focus on individuals or families as the locus for social change. Breaking with this approach, in the field of safeguarding there has been a turn towards thinking about systems in a wider sense, to include the social, political and cultural conditions in which we live our lives. Contextual Safeguarding (Firmin, 2015) for example and the recently published *Protecting Children: a Social Model* (Featherstone *et al.*, 2018) advocate this new way of thinking, which shifts us away from holding individuals accountable for social change, towards a consideration of communal or collective changes in the conditions which support and promote greater opportunities for well-being and safety. Some of their arguments echo Radical Social work of the 1970s in which community-based practice focused on working with people to improve their environmental circumstances, rather than asking *them* to change. Individualised models of workings - such as psychoanalytic and relationship-based practice - were denigrated during this time, creating a binary between psychologically-orientated approaches and community/collective action (Cornell, 2006). There is now however a fresh opportunity, in the light of systemic and psycho-social theory, to develop a both/and position around whether the individual or society

is the agent for social change (Ruch *et al.*, 2018). In this chapter, I explore the implications of these ideas for the FNP model.

My results also speak to contemporary critical research in the field of teenage mothers and fathers. SmithBattle (2018) argues that we are entering a 'revolutionary period' concerning the issue of teenage mothers, where the findings of extensive scholarship, that may previously have been dismissed as anomalous, will start to shift dominant assumptions about teenage mothers and fathers. My research contributes to the growing body of evidence that demonstrates how 'teenage parents' are not a single homogenous group (SmithBattle, 2018) and that being a teenage mother can offer just as much purpose and meaning as being a mother at any other stage of life. The young mothers and fathers in this study have shown me the importance of resisting the received idea that teenage mothers are inferior and that teenage motherhood comes about because of something lacking in the way that the mother was herself parented. As I elaborate below, through this research, FNP has the opportunity therefore, to be at the vanguard of several new academic movements which are pushing for evidence informed, ethical policy, developed with, and in response to, the lived experiences of mothers and fathers who are young.

This chapter is structured around three main headings, with several sub-points which expand on these, to offer specific recommendations for further consideration. The first two main points relate to learning about FNP's organisational functioning, whilst the third point relates to methodological implications for future academic research. I am particularly indebted to the work of Lee SmithBattle, who has a large body of qualitative scholarship within the USA on public health nursing and Vikki Reynolds, also an American scholar, whose work focuses on resisting burn out and collective action within therapeutic work.

Recognising and working with paradoxes: resisting binary thinking

The previous chapter highlighted the many paradoxes within the FNP model. These emanate from the experiences of teenage parents and the wider organisational

context. They are played out in a myriad of conscious and unconscious ways. Set-out below are three sub-points which invite FNP to think about the implications for its future development of the prevalence of paradoxes and binaries in the data.

1) Consider ways in which 'depressive position' thinking about the paradoxical nature of FNP's work can be supported and celebrated. This involves recognising the particular challenges of delivering a model which espouses humane, equitable, strengths-based approaches within a neoliberal, patriarchal and performative climate. It also involves an appreciation of the impact of working with the paradoxes inherent in giving birth, infancy and parenting (in general and as an adolescent), in a society that does not acknowledge or appreciate the nuances of these processes.

A 'depressive position' does not imply taking a negative stance about social change. However, it does encourage taking a realistic stance towards what can be achieved given the context of the work. The data showed how the FNP model sometimes gives rise to unrealistic hopes about what might be possible, the consequences of which were self-doubt and self-blame rather than a collective acknowledgement and deep understanding of the challenges of the task. This recommendation has implications therefore for nurse training but also other forms of communication internally and externally, so that FNP is not seduced into promising 'transformation' which may not be either necessary or possible.

2) Acknowledging how the conceptualisation, formulation and design of the FNP model are characterised by complex paradoxes which can be hard to see and hold in tension. Acknowledging the ethical complexity of this holding work for supervisors and nurses, and how their capacity to do this holding will be affected by the nature of the pressures and anxieties within the local context.

The discussion chapter highlights the ethical tensions inherent in the positioning of young parents within the FNP model. My intention was not to reveal incongruence that needs to be 'ironed out' (Rappaport, 1981). Rather I hoped to increase an understanding of the impact of these tensions on family nurses, who, as "street level bureaucrats" (Lipsky, 1980, cited in Hoggett, 2006) are asked to 'contain' disavowed

aspects of our society such as the deep-rooted, irrational hostility towards teenage parents, as mediated through official policy (Arai, 2009). Family nurses and supervisors exist within complex accountability frameworks. Whilst total congruence between policy and practice is not possible, there is the opportunity that further reflection and thinking about some of the key ethical tensions within the model design may alleviate the pressure on those delivering it. The research also clearly highlighted that some local teams are more equipped than others to integrate and ameliorate these tensions. More research is needed therefore to better understand the individual and contextual issues which enable supervisors to contain the internal and external anxieties and projections of their team.

3) Formally recognising and articulating the value of the relational aspects of the FNP model. Finding ways to “measure the unmeasurable” (Reynolds, 2011) and supporting nurses and clients to value the things that are harder to quantify. This could include exploring the potential for narrative and psychoanalytically informed methods (SmithBattle, Lorenz and Leander, 2013) alongside existing cognitive behaviour methods.

Prior to this study, little empirical evidence existed about the value of the relationships between family nurses and clients. My research sits alongside the work of SmithBattle in the USA to support FNP’s development agenda which is considering new ways of implementing the model. The findings from my research invite FNP to formalise their practice knowledge of the role of relationships within the FNP model. Although each family-nurse relationship is unique, the research suggests that there are broad similarities in terms of the values of humility and empowerment. This is enacted through family nurses positioning themselves as equal rather than superior to clients. Reflecting on this aspect of the work would allow for thinking about the different primary tasks involved in the family nurse role, and of appreciating and valuing these. In keeping with this and drawing again on the work of SmithBattle *et al. (ibid.)*, this research suggests that narrative based relational methods would fit within the value structure of the FNP model and would complement the cognitive behavioural methods currently used.

Promoting and sustaining parallel processes: Scaling up and digging down

This study was interested from the outset in the way that relationships affect relationships (Moore, 2007). As I have discussed, FNP's model of supervision intentionally includes a reflective and containing structure (Davys and Beddoe, 2009), so that family nurses model to parents the behaviours they hope to foster between them and their children. However, as the study has found, there are particular challenges to this within a marketised, deficit-focused wider organisational system and a public and policy environment negatively positioned towards teenage parents. The study has also thrown up the FNP model's reliance on individual and one-to-one relational processes. Both of these findings suggest that other forms of knowledge transfer might be amplified and formalised for greater impact and ethical re-balancing within the work.

1) Developing the role of systemic practice within organisational and public contexts (not just individuals and families) to develop understandings within FNP for what it means to work 'upstream' (SmithBattle, 2018). Involving clients and nurses in collective "justice-doing" (Reynolds, 2011) to create greater opportunity for social solidarity which changes the hostile context and re-balances power.

Vikki Reynolds (*ibid.*) highlights how individually focused efforts for creating change can lead to practitioner burn out. This she attributes less to vicarious trauma and more to one-sided work where there is no outlet for collective, structural action. She coined the idea of "the zone of fabulousness" – when practitioners are balanced between "justice doing" and responding to individual needs. This is echoed by SmithBattle (*ibid.*) who advocates the need for work 'upstream', by which she means structural action targeting the source of the problem – for example challenging the stigma experienced by teenage parents. Therefore, rather than, or alongside, asking what motivates a teenage parent to change, 'upstream' work may involve attempting to 'motivate' the cultural, public, political and social context to change. This could include clients self-organising to advocate together (Jupp, 2018) through minimal family nurse facilitation, or creating more opportunity for peer-support between both clients

and nurses in which advocacy, networks and collective action can take place. Working collectively at many levels could alleviate the sense of frustration and guilt that nurses feel when they cannot change everything for a client. It could also reduce nurses' overreliance on the techniques of the programme and the 'science' behind it. Shifting the focus to a both/and in terms of the individual and systemic activity might support new thinking about the supervision structure in which the sole responsibility for emotional containment sits with an individual supervisor. When work does focus on the individual family, a greater application of systemic thinking might also allow for the development of broader, richer, more culturally specific and shared definitions on what it means to want the 'best' for your child, which is contextually defined and reflective of the socio-economic circumstances and values within which babies are born and raised (Alldred and David, 2010). There is ample scope for FNP to develop a more deliberate collective ethic, that facilitates clients and nurses challenging the structures of power.

2) Recognising the effects of working with a client group so negatively socially constructed and politically powerless. Considering ways of resisting narratives in which teenage parents are objectified and undignified and spoken about as if they were a homogenous group. Promoting instead narratives which are congruent with clients' views of themselves and what FNP is to them. In doing this, drawing on the large body of qualitative research evidence which recognises the subjectivity of mothers and fathers who are "young".

The literature review and data highlight how teenage parents are often shamed, stigmatised and vilified within the media, policy, by professionals and the public. Despite its ubiquitous nature, however – much like the highly gendered expectations around parenting responsibilities – it was treated as something that had to be navigated and responded to individually rather than challenged collectively as unfair. Gaining a fuller understanding of this aspect of the work would, I suggest, benefit the FNP workforce. By bringing this into collective spaces, nurses, supervisors and NU managers are more likely to be alive to the

personal and collective defences that can arise from exposure to such hostility. A greater sense of organisational acknowledgement of the experiences of clients could increase empathy, appreciation and reflection on the impact of living with stigma and hostility and could also increase the workforces' sensitivity to how FNP practice can sometimes, inadvertently, reinforce these dominant views and depictions. This could involve, for example, recognising the ethical tensions within the work, particularly in terms of the language used to describe and position clients, and therefore offers rich potential for reflection and learning.

Renewed understandings of the context of the hostility experienced by FNP clients could also provide clarity on the value that clients attach to their family nurse experiences – as highlighted in this thesis. This could open up the way for client views on the FNP relationships to be heard in fresh ways within current feedback processes. Drawing on the large body of qualitative literature about the experiences of young parents could further bolster FNP's contribution towards reforming current assumptions in – public, policymaking and practice – about the 'problem' of teenage parenthood.

Advancing the recognition of psycho-social research methods

One of my research questions specifically focused on methodological issues relating to the value of adopting a psycho-social approach. Whilst I have documented my reflexive process about this, I return to this question here, to consider the merits of the epistemological and ontological frame I utilised, this time focusing on its contribution to wider scholarship. The rich and complex findings, and the National Unit's response to them, point to the merits of using a psycho-social methodology - informed by critical realism and undergirded by social constructionism - to understand complex practice based organisations. The conceptual lens deployed allowed me to hold an 'in-out' position: 'entering into' FNP practice, to some extent, from the inside, whilst also holding a critical lens from the 'outside'. Being 'inside', from a critical real perspective, meant seeing the world *with* participants as much as possible, trying to apprehend and appreciate their experiences and frames of reference, as if these perspectives were

‘real’. This was greatly advanced by being embedded within the research field and developing trusting, respectful relationships with participants. From a psycho-social perspective, it also meant gaining experience of what FNP *feels* like, again facilitated by the messy process of being alongside and carefully observing clients and nurses consistently, over time.

At the same time, my ‘outsideness’ allowed me to see paradoxes and complexity. This was accessed through experiencing and reflecting on the affective processes at play, and marrying this with critical real and social constructionist orientated questioning of underlying structures and systems. The significance of relational processes within FNP meant that a methodology which utilised relational methods so centrally was particularly generative in this regard. It allowed me to uncover concepts and phenomena which exist in parallel processes across and within the complex strata of FNP’s organisational system. Below I will set out two specific implications relating to this methodological question, which have emerged from the research process.

1) A psycho-social methodology and research methods are effective for knowledge building within complex organisations and practice settings.

This study has demonstrated the validity of deploying psycho-social research methods for understanding the FNP model. These have facilitated a genuinely multi-perspective position in relation to the data, whereby the views of clients, professionals and policymakers are considered together. It also enabled me to bring in multiple theoretical frames of reference, including systemic theory, sociological research and cultural criticism – in acknowledgement of how complex social problems are, by definition, inter-disciplinary and benefit from going ‘beneath the surface’. The research has shown that psycho-social methods are useful for resisting dualistic, binaried interpretations in favour of humane and generative explanations, enabling a rich account of the complex interconnectedness of policy and practice within a contemporary organisation to emerge. This stands as an example for others with similar aims and interests to develop and expand these methods further.

2) Recognising the personal impact of psycho-social research methodologies on the researcher, and the value of practice skills within the research context.

As an emerging field, there is little scholarship within the social sciences about the experience of undertaking empirical psycho-social research, the skills and capacity needed by the researcher or what is needed within their support context in terms of supervision and support. There is even less about the experience of research subjects of taking part in psycho-social research as a participant and/or collaborative partner. This thesis therefore, contributes to an emerging field, where researchers are learning about this way of learning about the world. Whilst this approach is richly rewarding, offering the potential for deep insights into social issues, it can also be daunting and comes at a high emotional cost for the researcher. More guidance is needed to widen the accessibility of methods which enable thinking 'beneath the surface' about complex human problems, and also to ensure that they are undertaken within safe structures. In particular, I have drawn on social work skills at several stages of undertaking this research, including empathy, communication skills and creativity. Other disciplines may bring other things to empirical psycho-social research, however, I have learnt that social work, as an inter-disciplinary profession, with traditions in both therapeutic and emancipatory practice is particularly suited to this approach.

Implications beyond FNP

This study has primarily focused on operationalisation within FNP. In this section however, I focus on the study's implications beyond FNP. The literature review highlights the contextual and methodological crossovers with sector partners, including community nursing, voluntary sector family organisations and early intervention practice. With this wider field in mind, I have set out below the implications for a) research, b) policy and c) practice¹⁰.

¹⁰ In order to reflect the change in focus here, the term 'service user' replaces the FNP-specific term 'client'.

Research implications

I have highlighted above the potential for research methodologies which advance psycho-social, critical real and social constructionist understandings of complex practice and organisational settings, particularly when the perspectives of both professionals and services users are being sought. There are, however, research implications beyond methodological ones, as set out below.

Extending research agendas around: i) young parents; ii) inter-disciplinary learning, and iii) relationships based practice.

i) Young Parents

The juxtaposition between received ideas about the ‘problem’ of young parenthood, and the views of study participants in this and other research, highlights the need for greater and more nuanced understandings of this divide. Given the policy attention on young parents, it is imperative that their experiences, views and perspectives are better understood and integrated into policy responses. This includes extending current understandings about how and why young parents cope and thrive, especially in the light of the stigmatisation they face.

In addition, if it is the case that the stigmatisation of young parents by professionals and the public is as extensive and normalised as this, and other research, would suggest, then there is need for further collaborative research advancing understandings of young parenthood as a social justice and human rights issue.

ii) Interdisciplinary research

One of the perhaps more unusual aspects of this study is that it is social work research about a nursing intervention. Whilst there has not been space to explore this feature in detail, it nevertheless highlights the possibilities for other studies which offer a lens from one discipline, onto another. This study’s inter-disciplinary approach throws into relief received ideas of what doing ‘social work research’ means. By not focussing on a social work subject, it sheds light on how the discipline of social work – its values, ethics, practice skills and criticality - translate into

research approaches. As such, this thesis adds weight to the idea that complex social phenomena, such as teenage parenting, require innovative and multi-disciplinary responses, and that there is much enrichment to be gained from this type of cross-fertilisation.

iii) Relationship-based practice

This study indicated that those young people who had accepted the offer of support from FNP experienced a great deal of relational satisfaction. The implications of this for policy making are explored below. However, in addition to this, the research raised questions about those young people who declined FNP, partly based on its relational expectations. Given the apparent vulnerability of this group and the increasing policy interest in targeting the most vulnerable, further research is needed to understand the nature of access to relationship-based interventions. This includes learning about how a voluntary intervention such as FNP, which relies on intensive relational contact can be tailored towards those whose life experiences make it very difficult for them to recognise its potential benefits to them.

Policy implications

i) Acknowledging and reviewing the impact of neoliberal policies and austerity politics on teenage parenting policy and ii) investment in, and measurement of, relationship-based interventions.

i) Neoliberal policies and austerity politics

This research problematises several policy agendas which impact FNP and its sector partners. As the literature review highlights, these partners include family service voluntary and statutory providers, community health services and the multiplicity of services and providers which sit under the banner of 'early intervention'. Their commonality with FNP makes it likely that policy agendas affecting FNP, also affect sector partners, including:

- The prioritisation of individualist understandings and responses to social problems over structural explanations, such as poverty, or a lack of access to education and career opportunities.
- The uncritical adoption of a neurobiological lens, in which the quality of 'parenting' is measured against culturally and socially specific norms, leading to the de-prioritisation of community and strengths-based responses.
- The problematisation of 'risky' life trajectories which do not follow the ideal economic citizen model.
- A fixation on the idea that a particular method or model can be tested as if it is a mechanical process according to whether it 'works', rather than acknowledging the complexity and paradoxes within all human interaction, and therefore services. This leading to unrealistic pressure to numerically quantify activity which fails to capture or value meanings which are important to service users and practitioners.
- The competitive commissioning environment which places middle managers and practitioners in highly complex accountability arrangements that have a high personal, ethical and emotional cost.
- The impacts of cuts to welfare services to individuals and organisations, including expectations to achieve the same with fewer resources; and the uncritically applied imperative to 'target those most vulnerable/in need' with the few public resources that remain.

The overarching implication of these findings is for social policy to take a more nuanced, ethical, realistic and collaborative approach to framing social 'problems', envisioning outcomes and designing interventions. This would be informed to a

much greater degree by the experiences of those who deliver and 'receive' service, and by a recognition of how individual problems are structurally scaffolded.

ii) Investing in relationship-based interventions

For policymakers wanting to understand the value of interventions that prioritise relational practice, this study offers theoretical and conceptual explanatory power to support narratives 'on the ground'. The data indicates that long term, consistent relational support can have enfranchising and empowering effects on people who live with socially harmful, marginalising experiences and disadvantage. In this study and others, the professional relationships which were most appreciated by service users, and therefore most 'effective' in this regard, are those characterised by respect, genuineness, humility, kindness and care.

Effective service user-professional relationships cannot be formularised, however. They are, by definition, dynamic and idiosyncratic, each one created by the unique combination of particular people, coming together, encountering each other. The positive characteristics described above, coupled with this uniqueness, provides the basis for trust and growth, safety and experimentation. Relationships of this kind hold a range of diverse meanings for service users, which can be drawn on in multiple ways. However, these meanings, despite their importance for service users, are often hard to fit within traditional outcome measurements. This research suggests therefore that more sophisticated qualitative frameworks are required for capturing the richness and depth of relationship-based practice.

Practice implications

i) Organisational reflection on the ethical field; ii) responding with resistance practices; and iii) broadening supervisory structures.

i) Realistic organisational reflection on the ethical field

One of the most significant practice implications for organisations working within the policy agendas outlined above is the need for organisational reflection. The purpose of this is to understand and acknowledge how these policy agendas impact

particular contexts and to resist binary and formulaic thinking and practicing. As with FNP, it is likely that organisations delivering services under NPM, especially within austerity, will encounter conflicts between policy demands and their core values, and find themselves engaging in splitting and other forms of polarised thinking. Committed, on-going reflection should enable practitioners and managers to recognise and name the sorts of complex ethical conflicts highlighted in this study, to consider their effects from different vantage points and appreciate their emotional impact throughout the organisational system. By doing so, it is hoped that they will be in a better position to engage in more integrated, realistic, 'depressive position' thinking and practice.

Rather than blaming organisations and practitioners for enacting practice that might seem ethically inconsistent, this research has drawn attention to the conflicting, complex and paradoxical nature of organisational practice under NPM, especially within a highly contested area such as teenage parenting. Organisational reflection could enhance awareness of how policy agendas have been assimilated uncritically into practice. This may uncover, for example noticing language or attitudes which normalise structural inequality, or a realisation that goal-setting practice expects individuals to change their behaviour, without attention given to the systemic context in which issues arise.

ii) Responding with resistance practices

Once an organisation is more fully aware of its ethical field under NPM, there are opportunities for practice responses which enable 'justice doing' beyond individual casework. One example is developing collective ethics which focus on changing societal structures rather than individual service users, as an act of resistance to a policy agenda which individualises problems. Another is championing those things which service users value, alongside traditional measures of 'success'. Within a highly quantified data-gathering environment, noticing and holding onto 'strange successes' as they are called in this thesis, can be counter cultural and help to resist disempowering narratives about what matters. It is very hard for an individual worker to maintain this sort of resistance practice alone. Rather it requires

organisational support and sanctioning, including the development of a safe and collegiate working environment and opportunities for case-working practitioners to take part in leadership activities within their local context.

iii) Broadening supervisory structures.

There are also implications from this study related to supervision. One of these is about the importance of organisational containment at the middle-management level. Although roles at this level can be particularly vulnerable to the sort of ethical complexities described above, containing supervision can be hard to achieve here, even in an organisation like FNP, which has an advanced supervisory structure. The data also warns against supervisory models which inadvertently replicate an individualised approach in which a supervisor holds the sole responsibility for the organisational containment of numerous practitioners. Rather, I have highlighted the possibility for sharing the effects of working in a helping capacity with marginalised and disempowered people between team members, such that there are both vertical and horizontal relationships of containment and support.

Conclusion

The implications for this research are relevant to FNP NU, the wider workforce, the social scientific community and those interested in the links between social policy and practice. I have invited readers to consider anew the way that teenage parents are stigmatised and judged within society and the multiple ways in which this affects the delivery of the FNP model. During the writing up of this thesis, I had a sense of myself as undertaking an act of intellectual and affective appreciation. By this I mean the sort of apprehension, discussed earlier, which makes use of Judith Butler's term 'recognition' (i.e. Waterhouse and McGhee, 2015). Just as family nurses seek to appreciate, apprehend and recognise the humanity of their clients, this research has brought my full and sustained attention to bear on the FNP model. The result is something akin to a 'formulation' developed by a psychotherapist during their assessment of a client before they embark on the treatment process. A therapist claims no expertise over the lives of their clients. Rather they offer their intellect, skills

and emotions in the service of thinking with the other person about what might be going on. In the same way, I have sat with the FNP model, as embodied through the people who have shown it to me and tried to work out what might 'going on'. This thesis is my 'formulation' of the obstacles and opportunities I perceived within the implementation of the FNP model, which are offered to the NU to develop and consider as they see fit.

Chapter 9: Conclusion

In their book *Re/Assembling the Pregnant and Parenting Teenager*, Kamp and McSharry write that “teenage pregnancy and parenting is not one thing, even within the experience of one teenager” (2018, p. 9). It is a simple statement, but my heart leapt when I read it because it spoke so directly to my experience of conducting this PhD which involved researching an intervention model within this highly contested, ethically and politically sensitive area. Societal and political narratives alike seek to ‘fix’ teenage parenting, in terms of how it is seen (an unmitigated disaster) or in how it ought to be responded to (eliminated). This study has sought to contribute to an ‘unfixing’ of this narrative so that it becomes more fluid and nuanced, and better reflects the experiences of teenage parents.

In the spring of 2018, I attended a presentation in which the FNP Director discussed emergent findings from a significant service development programme instigated in the wake of initial RCT findings which, as I have said, were less positive than hoped. In the presentation, she discussed the Japanese concept of Kintsugi – the practice of mending a broken object, like a bowl, such that the breaks are highlighted using a special gold-coloured glue. The point of the metaphor is that the new lines create an even more beautiful object than the original bowl. This is a depressive position image, which was used in the example to consider FNP’s experiences of learning and growing as an organisation. It also made me think about the experiences of individual young parents within the study, who talked about how their lives had been immeasurably transformed for the better by having a child, in the context of considerable hardship. This is a complex paradox and not a formula - we do not deliberately break bowls so that they can be fixed with gold glue, and the framing of teenage parenthood as a ‘bowl breaking’ experience, is, as I have described highly contextual. However, the point is that something beautiful and even better *can* emerge out of experiences of adversity in both individual and organisational life. Linking in with Kamp and McSharry’s idea of fixing and unfixing (*ibid.*) above, this is an example of thinking which creates a space to think about human and organisational life as non-linear, promoting

‘both/and’ rather than an ‘either/or’ position. Such thinking provides fertile ground for taking up the ideas developed within this thesis.

The social worker and psychotherapist Clare Winnicott, working in the 1960s, drew attention to how easy it is to slip into the reification of techniques and structures as ‘formulas’, and the importance of resisting these in favour of something which she calls “truly dynamic and productive” (1964, p. 8). Reification refers to our tendency to forget how human phenomena are socially constructed, treating them rather as if they were innate or naturally occurring. Winnicott is interested here in how to keep the professional relationship between client and practitioner centre stage. She suggests that being open to the humanity, uniqueness and difference within each encounter can help to mitigate against the reification of tools and techniques because the “reified world is by definition a dehumanized world” (Berger and Luckmann, 1991, p. 106). This thesis has drawn attention to the human encounters between teenage parents and family nurses, and how these can powerfully disrupt the formulaic approaches to conducting relationships, creating new and diverse primary tasks.

Finally, Froggett’s book *Love, hate and welfare* (2002) provides a psycho-social account of the various welfare models employed in the UK since the second world war. One of the themes she identifies in late modern Britain, drawing on the work of Fraser and Honneth (1995, p. 133), is the tension which sometimes exists between a model of welfare focused on the idea of *recognition* – the validation of a group - and one which focuses on *redistribution* – the achievement of equality for group members so that it ceases to be seen as a group. Within FNP I saw both a recognition agenda (e.g. advocating for a teenage mother to be treated respectfully) and a redistribution agenda (e.g. encouraging a teenage mother to go back to education) at play. My analysis of FNP’s sometimes paradoxical model design should be seen therefore within the context of a conflicted late modern welfare project, in which teenage parents are situated as manifestly disempowered such that any recognition or redistribution work is usually done on their behalf rather than via self-led, collective, deliberate activity. I hope that this thesis will contribute to a shift in this balance so that mothers and fathers can experience a less hostile environment within which to bring up their

children, enjoy greater respect, and have increasing say over how they are responded to by social policy in the UK.

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Appendix A: Core components of FNP intervention and implementation

Whilst there have been recent adaptations allowing flexibility with regards some programme elements at the local level, what follows is the core FNP programme elements in England, as developed over the first decade of implementation.

Key features and eligibility

- Mothers join the programme early in their pregnancy. FNP aims to have 60% by 16 weeks gestation.
- They must be first time parents, aged under 19 years of age at their Last Menstrual Period (LMP), agree to the service and live in an area where FNP is provided.
- The service continues until the child's second birthday.

Approach

- Family Nurses develop a helping/therapeutic relationship with parents and work with wider family members where possible through weekly/bi-weekly home visits.
- They adopt a non-judgemental, strengths-based approach aimed at promoting change through improving the self-efficacy of parents.
- Family Nurses follow a manual of psycho-educational material focusing on the particular developmental stage of each family, working in collaboration with the parents to find the right pace and content for visits.

Implementation

- Nurses have a smaller case-load than their health-visiting or midwifery colleagues to allow for a relationship-based approach (a maximum of 25 cases for each FTE family nurse).
- There is a strong emphasis on supervision, training and support which acknowledges the emotional impact of the work.
- There is a wish/intention for the relationship-based approach which nurses adopt with clients to be a consistent thread throughout the organisational system.

Outcomes

To enable young parents:

- To improve their pregnancy outcomes so that their baby has the best start in life.
- To improve their child's health and development by developing their parenting knowledge and skills.
- To improve parents' economic self-sufficiency helping them to achieve their aspirations (such as employment or returning to education).

This further enables young parents to:

- Build positive relationships with their baby and understand their baby's needs.
- Make positive lifestyle choices that will give their child the best possible start in life.
- Build their self-efficacy.
- Build positive relationships with others, modelled by building a positive relationship with the family nurse.

Appendix B: Example Information Sheet and Consent form

Information Sheet for Family Nurse Partnership Staff Stage 1

Researcher's contact details: [removed]

Welcome

My name is Rachael. I would like to invite you to take part in this research study. It is your choice whether you take part. In order for you to decide, I would like to explain why the research is taking place and what it would involve for you. Please do not hesitate to ask if anything is not clear.

Do I have to take part?

No. Being part of the study is entirely your choice. If you do decide to take part, you will be asked to sign a consent form so that I am clear that you are happy to take part. Even if you decide to take part, you are free to change your mind at any time without giving a reason. If you have questions or worries, I am very happy to talk about them with you.

Why the study is taking place?

The study is taking place in order to better understand the Family Nurse Partnership (FNP) way of working. It was initiated by FNP National Unit in order to improve their service to young parents. I have been asked to be the researcher on this study as part of my PhD in Social Work and Social Care at the University of Sussex. My background is as a practitioner with children and families and my academic interests include learning about how organisations like FNP use relationships to work with people across systems (micro, meso and macro).

Research design and methodology

This is a qualitative, ethnographic and psycho-social study. I am interested in learning about and not evaluating what I see. I plan to be involved with your team for approximately 9 months on a part-time basis. It is important that your team feels comfortable with the research, so the schedule can be reviewed at any time.

What is involved?

Observations

Home visits

I would like to join you on home-visits to FNP clients. I will not take part, just watch and listen. After the visit I will write up notes to remember what happened. I'll be interested in talking to you before and after the visit about your reflections. I do not know exactly how many visits I will ask to observe with you. My aim is to observe a diverse variety of FNP clients.

Professional meetings

If the client, you, and others taking part are willing, I may ask to observe some meetings which involve other professionals. Like with the home visit, I will not be taking part in what is going on, just watching and listening.

Intra-team discussions and meetings

I am interested in the day-to-day 'ordinary' activities that take place in your team. I hope to observe, for example, informal discussions about FNP clients as well as some supervision sessions. As with all of these activities, your involvement is voluntary and you are free to change your mind at any time according to how you feel about each situation.

Interviews

I may also ask you if you would be willing to speak to me in a research interview. This will be an open conversation exploring your thoughts and feelings about FNP.

The interview will last about an hour. If you are willing, I would like to audio record the interview which will then be written up by a professional who abides by a confidentiality code. You can choose not to have the interview recorded.

Other participants

The research also involves interviewing and observing FNP clients, their close family and friends and linked professionals about their experiences of FNP. The interviews will be similarly open, and take a strengths-based, explorative approach.

Why have I been invited to take part?

The FNP team where you work has been selected for this study. Every Family Nurse in your team is invited to take part. If you agree to take part, everyone on your FNP clients will also be eligible to take part.

What will happen if I don't want to carry on with the study?

It is your choice to take part in the study and your choice to stop being involved. You can choose whether you want me to destroy any information I may have gathered about you up to that point (for example notes about a home-visit) or not.

Keeping things confidential

Your involvement in this study will be kept confidential. The notes I keep will be made anonymous. Any personal details like your name will be kept securely and separately from my notes. I will use a code to identify you (like an initial) so that no one would be able to tell you were part of the research if they looked at my notes. Only I will know the code. Because I am studying for a PhD, I will discuss the research with my supervisor, but I will not tell her who you are. Any information which could link you to the research study will be destroyed when the study is over.

When I analyse and present the research data, you will not be identifiable. This is because I will change details and write case studies which are made up of a number of different people's experiences. I may quote things you have said, but only you and the people who actually heard you say it will know that they are your words. I will not identify the area of the country you live in or name the FNP team you are linked to.

Breaking confidentiality

If, during the course of the research, I learn about someone being in danger then I will follow your local safeguarding and information sharing procedures. Likewise, if I encounter professional misconduct, I will follow the local whistle blowing policy.

Risks and benefits of taking part

This is not thought to be a high-risk study. It is not common for people to become upset when being observed or interviewed by someone who is friendly and whom they trust. If you do, I will be happy to stop straightaway. Sometimes people find being part of research a positive experience. This is because the researcher is able to appreciate their work in more detail than most other people are able to, and this feels helpful. I hope that you will feel positive about the fact that your FNP experiences have helped to develop a better understanding of FNP. This is one of the first research studies about FNP which includes listening to clients about their

experiences, so you will be contributing to both new knowledge and a new way of learning about how organisational systems work.

Making sure the research study is ethical

In order to make sure this study respects the dignity, rights, safety and well-being of participants it has been submitted for NHS ethical review through the HRA. This involved meeting with an NHS Research and Ethics Committee which is made up of independent people who look closely at the plan to make sure it is in line with legislation and good practice. They have given approval of this study. I will also be meeting regularly with experienced supervisors.

The end of the study

I will be writing a thesis for examination for my PhD study. FNP National Unit are interested in what I learn and will be using it to improve services for young parents. They will produce summaries of the findings to publish in places like their website. I, or the National Unit, might also present a summary of the findings at conferences for example and I will write papers for publication.

Who else is part of the research? [Supervisor and NU Advisor removed]

Academic Supervisor and NU Advisor contact information [removed]

If you are unhappy with any aspect of this research study and would like to discuss this or make a complaint, please contact Gillian Ruch on the contact information above.

Consent Form

Thank you for considering taking part in this research. If you have any questions, please ask a member of the research team before you decide to take part. The team is as follows:

[removed]

Once you have decided to participate you can decide that you no longer wish to be part of the study at any point.

Please tick 'Yes' or 'No' box as applicable:

	Question	Yes	No
1	I confirm that I have read and understood the information in the information sheet for the above study.		
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
3	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any current support or care or legal rights being affected.		
4	I understand that if I withdraw from the study the data collected up to this point which concerns me can be destroyed if I wish it to be.		
5	I agree to take part in the study.		
6	I understand that data from the study may be looked at by the research team. I give permission for these persons to have access to this data.		
7	Where applicable, I agree to the interview/focus group (delete as appropriate) being audio recorded so that my comments can be typed up and used as research data.		
8	I understand that if you tell me that someone is in danger/I learn about professional misconduct (delete as appropriate) whilst doing the research, then this will need to be shared in order to keep those involved safe.		

Name of Participant (please print): _____

Signed _____ **Date** _____

Name of Researcher: Rachael Owens

Signed _____ **Date** _____

Appendix C: Focus group plan for FNP Clients

On arrival:

- Welcome informally
- Hand out the information sheets and talk people through them
- Get consent forms signed
- Give out travel expenses
- Invite people to take refreshments
- Aim to begin at 1.30pm

Welcome	I am a researcher from University of Sussex. I'm doing a research study about the Family Nurse Partnership – check if everyone is happy with 'FNP' as an abbreviation? I was asked to do this research by FNP's National Unit – like their Head Office, because they want to understand better and in more depth what FNP does. Supporting me today is [name removed], who is part of the FNP research team.
Our topic today	Thank you for taking the time today to come and talk to us about your experience of the Family Nurse Partnership, or the FNP. You were invited because you're either a client or past client of the FNP, or you're a close friend or family member of someone who had taken part in FNP. We want to know honestly about what it's like for you, being part of the FNP programme.
Guidelines	What's really important is – there are no right or wrong answers. You will probably have differing points of view from other people and we are very interested in these. Remember that we are just as interested in 'negative' as well as 'positive' experiences (and anything in between). Sometimes hearing about what has been difficult can even be most helpful. Above all, this is about you talking to each other, with us here to listen and guide the discussion. We ask that you turn off your phones, if possible, but if you can't and need to take a call, please do it as quietly as possible and re-join us as quickly as you can. As you know, we're recording, because we don't want to miss anything anyone says. It does mean though that we have to only speak one at a time, so we can make sure everything is captured. We're using first names today, and we won't be using any names in any reports we later go on to write. It will be completely confidential – no one will be able to tell you have been part of this study from reading the report. The report will go back to the FNP National Unit, to help them to plan for the future of this programme. We have about an hour and a half, so we can take our time. Any questions before we begin?
Introduction	Shall we begin by going around the table, introduce ourselves and saying what stage we are at in the FNP programme?

All the way through....	Would you explain further?
	Would you give an example?
	Is there <i>something</i> else you want to tell me?
	What are you thinking? How do you feel about that? How about others?

First question

First encounters	Think back to the first time you were first told about the FNP, what do you remember? What were you feeling? What were you thinking? How about your first meeting with your FNP nurse, what do you remember? Feeling & Thinking? What was happening in your life then? What were the first things you did together?
At the start – Yes or no to FNP?	Was anyone a bit unsure about whether to say yes to having a FN? If no – why not? If yes - what made you decide to do it? (Do you know anyone who decided not to have a FN? – what can you tell us about their decision)

Overall programme

Draw a mind map together	Let's think together about all the different things that you do with your family nurse? <ul style="list-style-type: none"> - Talk (what about?) - Go to appointments (which ones?) - Learn (what kinds of things?) - Practice things (like what?) - Play etc. (what kind of playing?)
Telling a friend	If you were to tell a friend about the FNP, what sort of things would you say to them?
Most memorable moment	Thinking about all the time you've been having visits from a FN, what has been your most memorable/ stand out/ fondest moments?
Favourite	What's your favourite part of your FN's visits?
Persuading a friend	If you were to invite a friend to say yes to the FNP programme, what would you say?
Warning a friend	What would you tell them to watch out for?
Relationship Maybe in pairs and feed back to big group?	Thinking about your family, friends and other workers you have in your life – How is the FN the same as these? How is she different?
Relationship	What 3 words would you use to describe the relationship you have with your family nurse?
Surprise	What has been the more surprising thing that your FN has said or done something, like something you weren't expecting?

Eco-system	Think about one person who is close to you – like a parent, close friend, sibling, your child. What do you think <i>they</i> would say has been the impact of FNP in your life? <i>Take a minute to think about this.</i> What do <i>you</i> think the impact of FNP has been in their life?
Learning and changing	Looking back over the time since you began with the FNP. How do you think you have changed? What do you think you have learnt?

Specific parts of the programme

Facilitators	Do you recognise these things (facilitators)? What are these used for? What do you do with them? What do you think about them? Which ones can you remember? When have they been helpful? Not helpful?
Weighing	Does your Family Nurse weigh your child when she comes? Most of the time? Almost never? Etc. What's it like, having her do this?
Equipment	This is a photo of some of the equipment that FNs sometimes use. Do you recognise any of them? Which of these things, or other equipment have you used with your FN? What do you remember about them?
Ending	For those who have ended – what was this like? Is there anything would change about the ending?

Challenges

Eco-system	Have there been times when something your FN says or suggests you do, is different from advice you get from your family or friends? Can you give an example? What does this feel like? How did you manage it?
In charge	Imagine you were in charge of FNP – what would you change?
Least favourite	What's your least favourite part of the FN's visits? What's your least favourite part of the FNP programme?
Difficulties	Tell me about some of the challenges or difficulties you've had while you've had a FN?
Don't feel like it	What about the days when you don't really feel like seeing your FN that day? What does that feel like? What happens?

Conclusion

1. Summarise 2. Review purpose – has anything has been missed? 3. Thanks and dismissal

Afterwards:

Draw a diagram of seating arrangement; Check tape recordings; Debrief
Note themes, hunches, interpretations, and ideas
Compare and contrast this focus group to other groups
Label and file field notes, tapes and other materials

Appendix D: Adapted 'Listening Guide' and related recording processes

1. Listening guide process

Activity	Explanation
Select an interview to be transcribed	I selected a sample of interviews from each data source. Together they provided a representation of the whole data-set. For example, each of the nurses and their clients were represented.
Read and listen to the interview at the same time, highlighting themes	<p>I organised the interview script in landscape form and made columns on the right-hand side for my notes. As I listened to the interview, I marked the transcript with highlighter pen whenever there was a new idea or theme and wrote notes in the margin.</p> <p>-First reading - I listened for plot and reflexivity -Second reading - I listened for material that included 'I' statements (incl. 'me', 'you' and 'we'),</p> <p>After each listen, I added to:</p> <p>-“Themes and reflexivity” – grids on an excel spreadsheet recording key words and ideas coming out of each interview, noting links between interviews -“Qualities of relationships” – a document recording what each interview said about the quality of relationships featured within it -“Research questions” – a detailed table recording how the learning from each interview helped answer each of the research questions</p>

2. Image of Listening Guide scripts after two readings:



3. Example of data collated about relationships following LG process

I4	Fun, lots of laughter
I4	Able to bear expectations of the FN who supports her to make healthy choices about relationships - feels different from her mother's expectations of her – easier to accept than from her parents
I4	Lots of affirmation and reassurance

4. Example of how I organised the data according to the research questions, following LG process:

Research question: What are the opportunities and obstacles to operationalising the FNP model across the micro, meso and macro domains?

	Micro	Meso	Macro
Opportunities for model			
I1	Enabled him to get excited about his baby when all around was negative	I'd like more peer relationships please	Provide a voice for teenage fathers
Obstacles to model	Micro	Meso	Macro
I1	<p>The facilitators are hit and miss – one which was realistic about things we miss was great, others sugarcoat life and we laugh at them</p> <p>FN is not a young person just like them</p>	<p>Parent relationships make it hard for us to do what we want in term of parenting</p> <p>No sign of the MH help we need – are we on a list? I don't know ?</p> <p>Peer relationships are with older people with homes and jobs</p>	<p>Absence of MH support</p> <p>Drama school is hard to get into</p> <p>Drama is being cut from the curriculum</p>

Appendix E: Example 'I' poem

I2 – Poem 6 - If you've got something to say, say it

I don't know some stranger on the road.

You're a disgrace to the public having

children at such a young age.

You don't even know
how old I am. I could
be 26 or 27.
You don't know how
old I am.
You're so judgemental

You've ruined your life

How can I ruin my life having children

You lot are ridiculous.

I've ruined my life, says someone who's sitting here drinking alcohol

Come off it

We'll come and beat you up

Come and do what you're doing

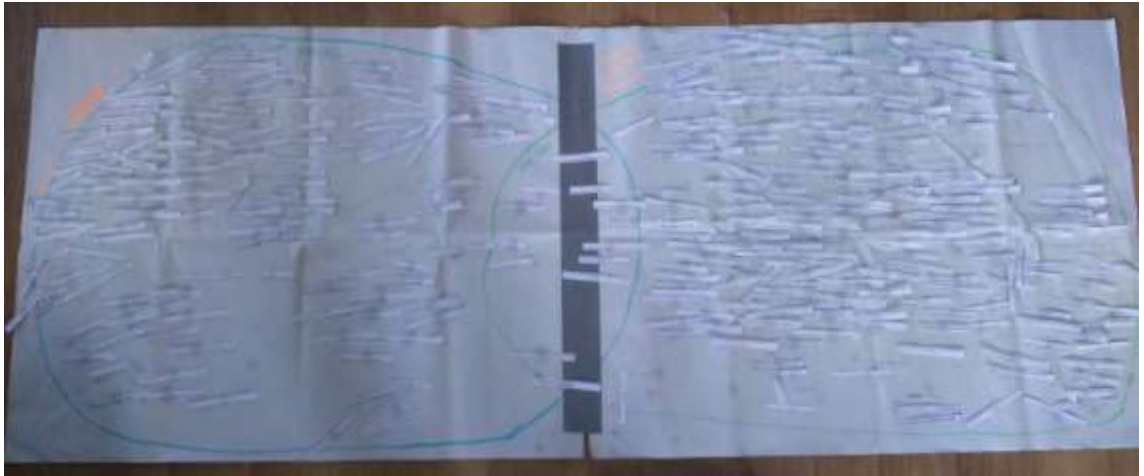
he just walked off.

It was so horrible

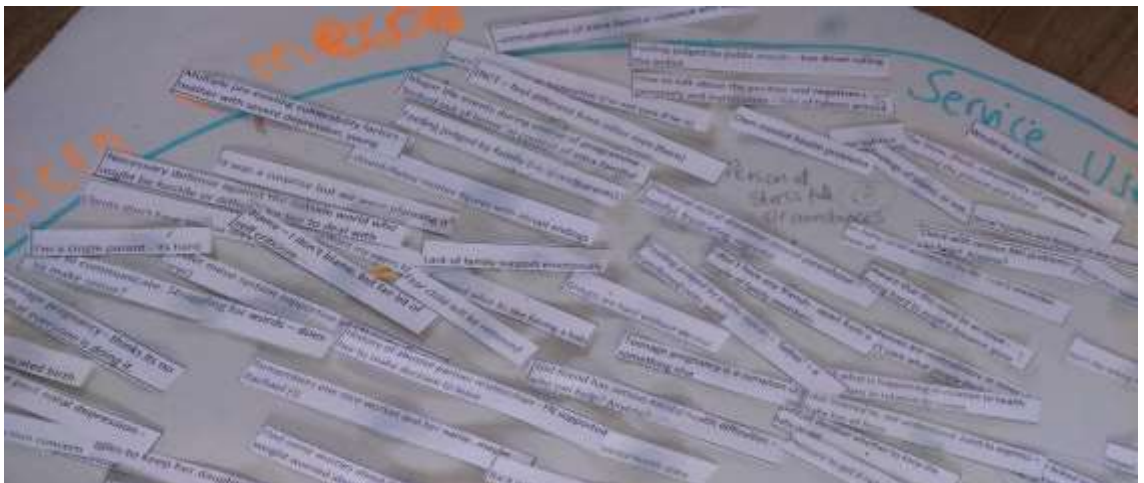
stop what you're talking you lot are so judgemental

Appendix F: Clustering process

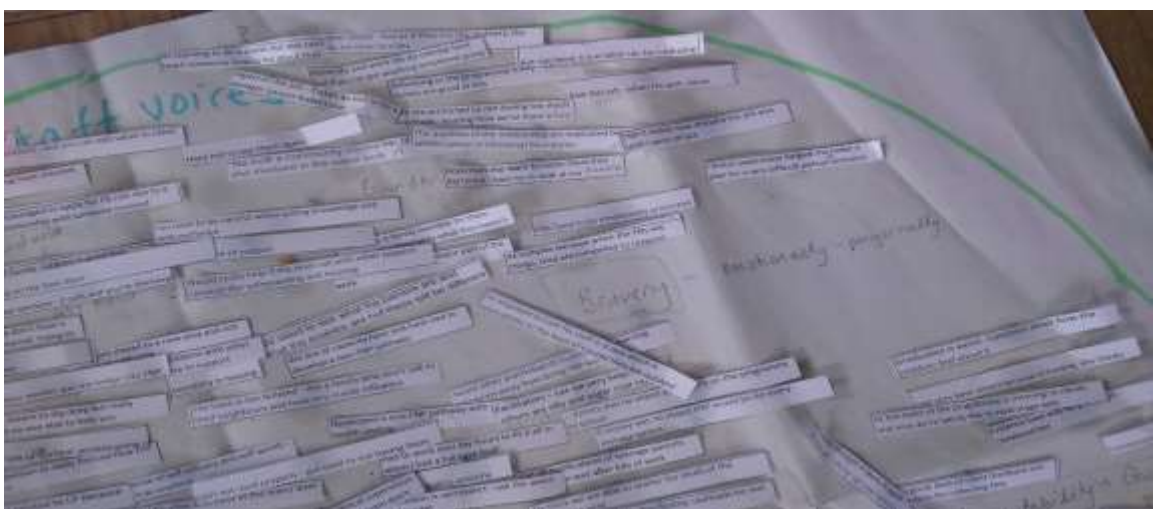
Overview:



Close up 1:

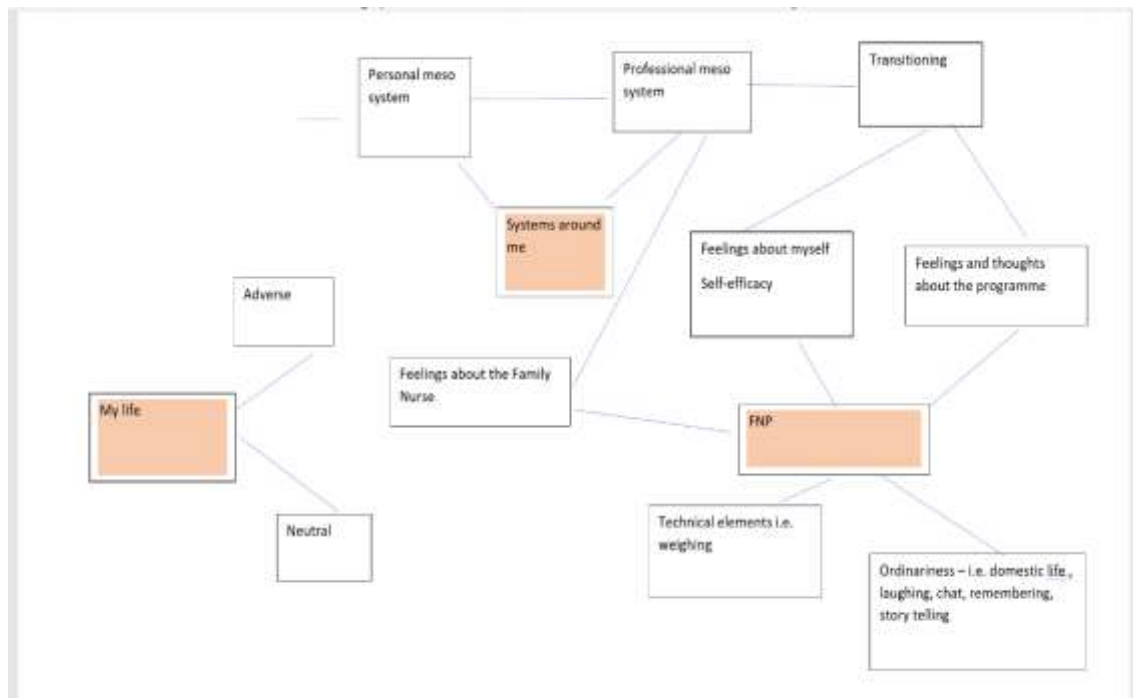


Close up 2:

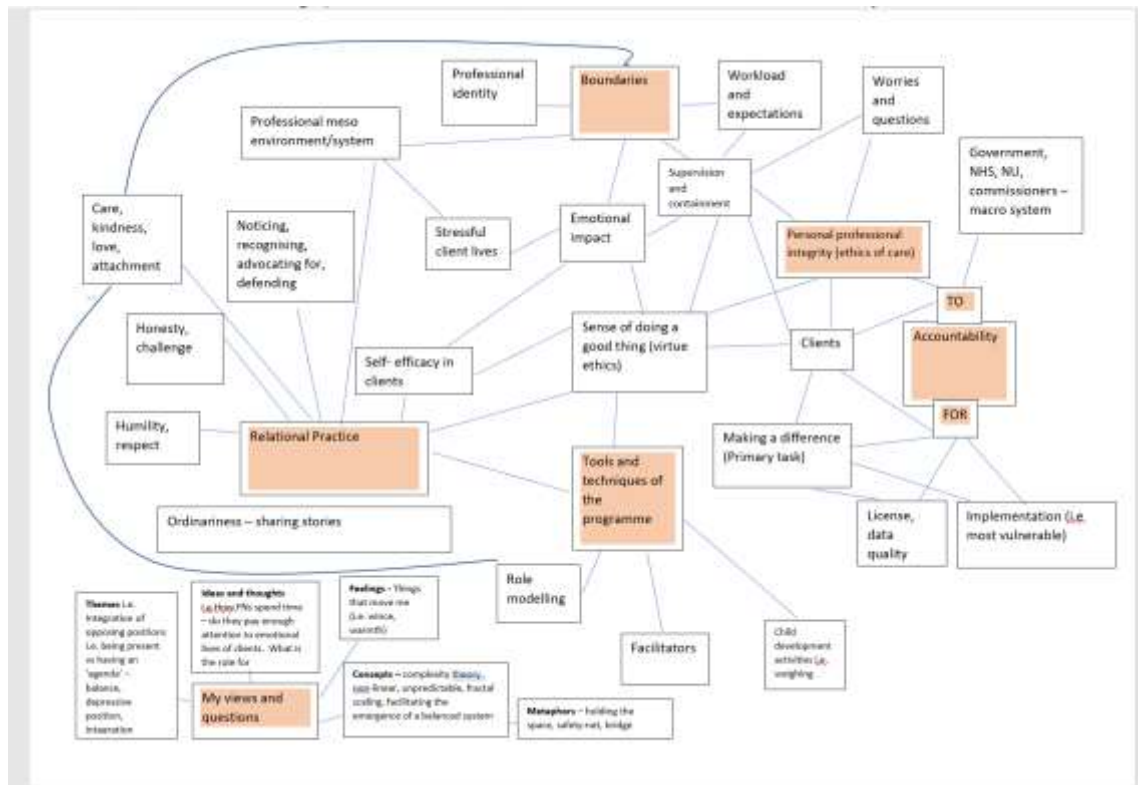


Appendix G: Mind-map templates

Clients:



Professionals:



[illegible]